Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Determen 20 June Gloria Johnson /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death County of Death **Examiner** Buttimor Waitington Gume med Lal Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye 6/14/25 Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Year) 1 □ M 2 🔀 F 81 Director 489-20-0979 Kansas Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. r 28a-f show notified at 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 N No Funeral Director Anne Arundel Co. Jessup 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code a or permit. Pages 1 and 2 should be filed within 72 hours after death w Department of Heath and Mehral Hygiene.
Important: If item 27 is marked other than "naturali, or items 23a any Injury or other traumatic event, the Medical Examiner must be USA 20794 7810 Clark Road., 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 XNo Completed by Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Edna Pinson Earl Taylor P 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Harold W. Johnson/Husband 7810 Clark Road., E-29, Jessup, MD 20794 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition ₩Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Meadowridge Memorial Park 11/1/06 Elkridge, Maryland 21. Signature of Funer dervice Licensee 22. Name and Address of Facility
Carry I., Kaufman Funeral Home @ MMP, Inc. 7250 Washington Blvd., Elkridge, MD 21075 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** rail Minau /Medical Due to (or as a cons-ouence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran and P.O. Box 68760, IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown cate has been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 1 Yes No No 3 Probably 4 Unknown 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1∐ Yes 2 No 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1X Inpatient Medical Certification: To 2 ☐ ER/Outpatient 3 ☐ DOA 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred Natural 2 Accident (Month, Day Year) Injury 5 Pending 1 ☐ Yes 2 ☐ No To the Hospital or Attendiwithin 24 hours after death.

To the Funeral Director: investigation 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Dav. Year) mas

State Registrar

31. Date filed (Month, Day, Year)

3 1 2006

30. Name and address of person who completed cause of death (Item 23a) (Type Print)

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32 Registrar Signatur

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- E	ţċ	Maryland	N/A			Ba	altimore					1 Yes 2 □ N
or 28	Director	10e. Street and Number			10f.	Zip Code	2420	)E		10g. Citizen	of What Co	•
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ury o		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		,		n Cemete			11/01/06		Baltimo	ore, Md.
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Jの中のSのA	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Health and Mental Hyglene. Important: if Item 27 is marked other than "natural", or Items 23a or 28a-1 show eny Injury or other treumatic event, the Medical Examinal must be notified at ances.	h i	4 Donation 5 Other (Specify) MT. ZION CEMETERY 11-1-2006 BALTIMORE, M  21. Signature of Funeral Service Licensee 22. Name and Address of Facility JAMES A. MORTON & SONS F										
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	To the Hospital or Attending Physician: The I within 24 hours after death, To the Funeral Director: After this certificate he completely filled in by the funeral director, page		29a. Certifier  (Check only 2   Medical Examin	ician: To the best of	my knowledge,	death occurred	at the tim	e, date and p	ace, and due to the	e cause(:	s) and manner as s	stated.	
	the H hin 24 the F nplete	fedical	one)	and manner state	ed.				occurred at the time	, date ar	nd place, and due t	o the cause(s)	
	To To	Σ	29b. Signature and title of certifier	1° 1 1	. ^		c. License		2		ate signed (Month,		
			r cyntur 8h	rano 1	14)	12	00	5154	/	10/	27/06	0	
	5		30. Name and address of person who con	npleted cause of dea	ath (Item 23a) (T	ype, Print)	1/11	1100	7 St. Bal	+111	1100 L	10 21.	204
	Sta		31. Date filed (Month Day, Year)	32 Registrar	ノーシール 's Signature	N.C	NU	VICS	11 2011	1100	10/6		
	Regist		OCT 3 1 200	The live	1 15 1	(A)GAGA!							

State of Maryland / Department of Health and Mental Hygieng 34504 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death October 25, 2006 ear Physician 8:00 P Mary P. Kolar /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Nottingham 9408 Danavista Road If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year May 31, 19 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□M 2**∏**F 85 217-40-5465 1921 Maruland Director Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits f Health and Mental Hygiene. Item 27 Is marked other then "naturel", or Items 23e or 28e-1 show other treumetic event, the Medical Exambrat retinal to incitited at 1 ☐ Yes 2X No Nottingham Director Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21236 9408 Danavista Road u.s.A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerlo Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. nent of Health and Mental Hygiene. ent: If item 27 Is marked other then "naturel", or Itel 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 X Widowed 4 □ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Medicine Registered Nurse 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Anthony Brazis Uzunaris Mary ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Nama/Relationship (Type, Print) Carol Bevans (daughter) 27 Heathrow Manor Ct., Baltimore, MD 21236 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1 Department of H Importent: If ite any injury or ot once. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Most Holy Redeemer 10/28/2006 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Homes 9705 Belair Rd., Baltimore, MD 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Porkinsons Physician 3222050 disease or condition resulting in death) V2119 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical Examiner The law requires that the death certificate be executed burjal-transit Due to (or as a consequence of) of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 2 No or Attending Physician: Certification; To Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 X Residence 6 Other (Specify) completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Natural 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 / Homicide 24 hours Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical within 2 To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number Notice Hud D31025 October 27,2006 30. Name and address of pers in who completed cause of death (Item 23a) (Type, Print)
Carla wolf Roserthal WiD. 3414 St Paul Street, Baltimore Mary land 21218 32 Registrar's Signature 31. Date filed (Month, Day, Year) State OCT 3 1 2006 Registrar

			State of Maryland / Department of Health and  1- State Registrer  State Of Maryland / Department of Health and  Certificate of Death		2000 34303
			1. Decedent's Name (First, Middle, Last)	Reg.	No.  3. Time of Death
	Physicia		Anne B. Klein	10 = 2 <	Day Year 9:00 P M
	/Medic Examin		4a Facility Name (If not institution, give street and number)  4b. City, Town, or Location of De	eath	4c. County of Death
			St. Elizabeth's ichab Ellusiglia Baltimore		N/A
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last withday) If Under 1 Year If Under 24 F	in. 8. Date of Birth Month, Day, Ye	9. Birthplace (State or Foreign Country)
	Director	4	Usual Residence of Decedent	1/22/19	/Y Maryland
	nyland how		10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits
	8a-fs	Director	MD Baltimore BAltimore		1 NYes 2 No
	with the	Dire	10e. Street and Number	10g.	Citizen of What Country?
	eath ns 23	Funerai	1015 +rancis I+ve 2(227  11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin?	(Specify Yes or No-	14. Race - American Indian,
(0	r Iten	Fun	Armed Forces? If Yes, specify Cuban, Mexican, Pu	erto Rican, etc.)	Black, White, etc.
03	ral', c	d by	3 Widowed 4 □ Divorced If Yes, Give Year or Dates: 1 □ Yes 2 No Specify:		Specify: White
21215-0036	be filed within 72 hours after death with the Maryland Hygiene. Hygiene dither than "natural", or items 23a or 28a-f show dither than "natural", or items 23a or 28a-f show avent, the Medical Evain for mind be notified at	Completed	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during most of kinds of work done during most of kinds of kin	working	nited States
12	filed withir Hygiene. Ither than ant, the M	шc	(Elementary/Secondary (0-12) College (1-4or 5+)		overnment
9	filed Hygi other	Be C	Tright School	Name (First, Middle, Main	
/lar		To B	Farley Jones Dor.	a Henson	
Maryland	2 a a a		19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or	Rural Route Number, Ci	
	of Health item 27 other tr		Susanne H. Buchta - Daughter 1013 Francis Ave., B.		
Baltimore,	S to L		20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)  20b. Place of Disposition (Name of cemetery, crematory or other place)	200	c. Location - City or Town, State
Ħ	permit. Pag Department Importent: i any injury o		*4 Donation 5 Other (Specify)  Loudon Park Cemetery 11/  21. Sign (up of Funer Service Lice see 22. Name and Address of Facility Ar	mbrose Funci	altimore, MD
B	Dep Imp One	V 14	1328 Sulphur Spr	ing Rd. Bal	timore, Maryland 2122
			23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as card shock, or heart failure. List only one cause on each line.		
	Physician		Immediate Cause (Final disease or condition AZNEIMERS dis	ease	Onset and Death V-P AVI
	/Medical Examiner		resulting in death)  Due to (or as a consequence of):		
		70	Sequentially list conditions if any, leading to immediate  Due to (or as a consequence of):		
Q.	uted d ansit	Examine	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated eyents		
<b>,</b>	an and		resulting in death) Last Due to (or as a consequence of):		
8760,	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	dicai	d	··	
9 ×	eath certific attending p	0	IF FEMALE: 23c. If yes, outcome of pregnancy		
Вох	atten I for u	cian	in the past 12 gronths?		23d. Date of delivery  Month Day Year
P.O.	at the de by the tached	Physician/M	1 ☐ Yes 2 ØNo 9 ☐ Unknown 9 ☐ Unknown		
S,	signed det	by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacc	co use contribute to the cause of death?
ord	w require been si should b	ted	My pertension	1 🗆 Yes	2 No 3 Probably 4 Unknown
Vital Records,	has b	Completed	Chronic atrial fibrillation	24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
alF	icien: The t certificate ha ector, page			performed	
	Physicien: this certificanal director,	o Be	examiner? V	Death (Check only one) g Home 5 Residence	C COther (Coorie)
of	g Phy er this	-	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at	28d. Describe how it	
Sior	endin sath. or: Aff	atio	2 Accident investigation M 1 Yes 2 No		
Division	el or Attending P s after death. il Director: After t id in by the funera	Certification;	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street City or Town, St	t and Number or Rural Route Number, tate)
	Hospitel or Attending 24 hours after death. Funerel Director: After tely filled in by the fune		29a. Certifier 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and pla		
	To the Hospitel or Atta within 24 hours after de To the Funerel Directa completely filled in by th	ledicai	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and plate (Check only one)  2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and plate and manner stated.	ace, and due to the cause courred at the time, dato	and place, and due to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier 29c. License number	29d.	Date signed (Month, Day, Year)
			D5539	11 00	tober 26, 2006
	2		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		
	٦		Ming VI MI) 3320 Senson / Venue, Sal 31. Date filed Month, Day, Year) 32. Restrar's Signature	timore, M	ory (and 21227
	Sta Registr		OCT 3 1 2006 Page & Back		

State of Maryland / Department of Health and Mental Hygien [ ] [ ] Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 29,2006 oCT. **Physician** 3:45 am DONALD KEITH /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 215 S. REGESTER STREET BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. APR. 11 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** , 1932 MARYLAND 74 Yrs 219-28-3035 Director Usual Residence of Decedent \*how 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r then "naturel", or items 23s or 28s-f show the Medical Examiner must be notified at 1XYes 2□No Director MD. N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 215 S. REGESTER STREET 21231 U.S.A. Funeral 12. Was Decedent Ever in U.S. Amed Forces? 1 ØYes 2 □ No If Yes, Give Year or Date\$ 9 4 9 - 5 3 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: if liem 27 is marked other then "naturel", or itsuportant: or other treumatic event, the Madical Exeminas once. 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: WHITE þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) DESIGNER PRINTING 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be L. HARRY KETTH SARAH TOHER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PHYLLIS KEITH/ WIFE 215 S. REGESTER STREET, BALTIMORE, MD. 21231 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State GARRISON FOREST V.A. 11/2/06 OWINGS MILLS, MD. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Bovice Licensee LTLLY & EILER INC. FUNERAL HOME 1901 EASTERN AVENUE, BALTIMORE, MD. 21231 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or a consequence of): **Physician** UNK. /Medical Examiner gortu Jalis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine physicien and s the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) P.O. Box 68760 Physician/Medicai as the nse 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ŏ in the past 12 months? Month Year Day 4 Pregnant at time of death 5 Other (specify) signed by the af ☐Yes 2☐No 9 Unknown 9 I Hoknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records. 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed certificate 1□ Yes No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one Hospital: 1 Inpatient Other: 4 Nursing Home Residence 6 Other (Specify) P 1 Yes 2√No 2 ER/Outpatient 3 DOA this 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Natural 2 Accident 5 Pending investigation within 24 hours after death. To the Funerel Director: A 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f Location (Street and Number or Rural Route Number, City or Town, State) illed in by determined 4 Homicide Hospital Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D3525U 10-31-06 30. Name and a ress of person who completed cause o' death (Ite 23a) (Type, Print) 200 Caten 31. Date filed (Month, Day, Year) 32. Begistrar's Signature State

DHMH 17 Rev 1/2001

Registrar

OCT 3 1

2006

		•	For State Registrar	State of Maryland / De	partment of Health a ertificate of Death	and Mental Hyg	giene 006	34507
10 mg	Physic /Medi		1. Decedent's Name (First, Middle, Las Lillian Ir	o ene Keller		2. Date of Dea Octobe	er 26,2006	3. Time of Death 5:13 P.M
*	Examir		4a. Facility Name (If not institution, give 12820 Eastern		4b. City, Town, or Location of Middle Riv	er	4c. County of Death Baltimo	
	Funeral Director		5. Social Security Number 215-22-6594 6. Security Number 11 11 11 11 11 11 11 11 11 11 11 11 11	7. Age (In yrs. last birthda 86 Yrs.	Months Days Hours	Min. June 21	y, Ygar 20 Mar	nplace (State or Foreign untry) yland
	he Maryland 8a-f ehow	Director	Md. 10b. County n/a	10c. City, Town or Balt:				10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	eth with the 23 or 23 or 23 or 23		705 South Grun		10f. Zip Code 21224		10g. Citizen of What Co-	
920	within 72 hours after deeth with the Maryland ene. then "naturel", or Items 23e or 28e-f show he Medical Examiner must be notified at	by Funeral	11. Marital Status  1 Never Married 2 Married  3 Model 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	<ol> <li>Was Decedent of Hispanic Orig If Yes, specify Cuban, Mexican, 1 ☐ Yes 2 No Specify:</li> </ol>	gin? (Specify Yes or No- , Puerto Rican, etc.)	14. Race - Amer Black, White Specify: Wh	e, etc.
Maryland 21215-0036	filed within 72 ho Hygiene. that then "natu int, the Medical	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12) 8+h	de completed) (G.	cedent's Usual Occupation ive kind of work done during most b. DO NOT use retired) Home Maker	of working	16b. Kind of Business/I	·
yland 2	be d la la	To Be C	17. Father's Name (First, Middle, Last) Anthony Dopko		Ма		gustyniak	
	les 1 and 2 s of Health ar of Item 27 is or other trau		19a. Informant's Name/Relationship (7)  Patricia Kirby  20a. Method of Disposition  1 ☑ Burial 2 □ Cremation 3 □	(daughter) 521	alling Address (Street and Numbe  19 Fourth Str  sposition (Name of rematory or other place)	eet Balti Date	more, Mar	yland21225 Town, State
Baltimore,	permit. Pages Depertment of I Important: If Ite any njury or or once.		4 Donation 5 Other (Specify 21. Signature of Funeral Service Licen  Tolut Cur	see O	vn Cemetery / 22. Name and Address of Facility  201 Dundalk	Kaczorows	Baltimore ki Funera	1 Home, PA
8760,	The law requires that the death certificate be executed so included by the attending physicien and be executed by the attending physicien and be detached for use as the burial-transit	dicai Examiner	23a. Part1. Enter the disease, or companies, or heart failure. List only disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. At Less Cerchine.  a. Due to (or as a consequence of):  d.				Approximate Interval Between Onset and Death  LUAMM
.O. Box 6	at the death certific by the attending p tached for use as:	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 Nho 9 ☐ Unknown		3 DEctopic pregnancy 5 Other (specify)		23d. Date of deli Month	ive <b>ry</b> Day Year
ords, P.	w requires that been signed I should be det	þ	Part II. Other significant conditions of	ontributing to death but not resulting in the	e underlying cause given in Part I.		obacco use contribute to	the cause of death?
of Vital Records,		e Completed	25. Was case referred to medical			1 ☐ Yes	rmed? prior to death? 2 No 1 Yes	topsy findings available completion of cause of
f Vii	nysic lis ce direc	To B	examiner?  1 Yes 2 No	Hospital: 1 Inpatient 2 ER/Outpa	0.1	of Death (Check only or rsing Home 5 Resid	dence 6 Other (Spec	sted Livin
Division o	Attending Ph death. ctor: After th y the funeral	Certification:	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be		y Work? M 1 Yes 2 1	No	now injury occurred	
Div	pltaf or A ours after eral Dire		4 ☐ Homicide determined  29a. Certifier 1 ☆ Certifying Ph	building, etc. (Specify)  ysician: To the best of my knowledge, de	eath occurred at the time, date and	City or Tow	cause(s) and manner as	stated
	To the Hos within 24 h To the Fur completely	Medical	(Check only 2 Medical Examone)	niner: On the basis of examination and/or and manner stated.	investigation, in my opinion, deat	th occurred at the time,	date and place, and due	to the cause(s)
	To with			15 m)	D379		29d. Date signed (Monti October 2	
	Sta Regist	ate rar		completed cause of death (Item 23a) (Tyr 1 i ams , M.D. 2801 32. Begistrar's Signature	·	ue Baltim	ore, Mary	land21224
DH	MH 17 Rev 1/2	2001			BINAL			

2006

BALTIMORE

WHITE

GOLD

Month

October 25, 2006

N. Charles St. Balto. Md 2120x

Day

Approximate Interval Between Onset and Death

weeks

Year

9. Birthplace (State or Foreign Country)
POLAND

10d, Inside City Limits

1 ☐ Yes 2 No

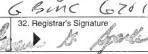
within 24 hours after death

To the Funeral Director:
completely filled in by the

Registrar

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier



and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5006

025205

		1- Samend #11 Per F	н <b>G860° 107317</b>	06 JHep	artment of rtificate o	Health and If Death	Mental Hyg	ene 006	34509
		1. Decedent's Name (First, Middle, Las	1)				2. Date of Deat	1	3. Time of Death
Physic /Med	lical	LOIS  4a. Facility Name (If not institution, give				PLAN	OCTOBER	26 2006	410 1
Exami	iner	JEWISH CONVALESC	107		BALTI	n, or Location of De MORE	ain	4c. County of Dea	-
Funera Director	_	5. Social Security Number 6. Social Security Number 6. Social Security Number 158–28–2598	TM 2DF	s. last birthday) 68 Yrs.	If Under 1 Ye Months Day		n. (Month, Day,	Year) 9. Bird	hplace (State or Foreignuntry)
D.		Usual Residence of Decedent  10a. State  10b. County		City, Town or Lo	antion		05/17/1	938	NJ
Maryla I-f sho	ţ	MD BALTIMO		BALTIM					10d. Inside City Limits 1 ☐ Yes 2X No
or 284	Oirec	10e. Street and Number			10f. Zip Code	9	10	g. Citizen of What Co	ountry?
ath w	Tag.	7920 SCOTTS LEVEL			2120			U.S.A.	
ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or iteme 23a or 28a-f show or other traumatic event, the Medical Examirar must be notified at	by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Married  2 □ Widowed 4 → ivorced	12. Was Decedent Ever in Armed Forces?  1 □ Yes 2 ▼ No If Yes, Give X Year or Dates:		Was Decedent of f Yes, specify C 1 ☐ Yes 2 ☑ N		(Specify Yes or No- orto Rican, etc.)	14. Race - Ame Black, Whit Specify:	
72 ho "natur	eted	15. Decedent's Ed (Specify only highest gra	ucation de completed)	(Give	dent's Usual Occ kind of work do	ne during most of w	orking	6b. Kind of Business	Industry
filed within Hygiene. Wher than "	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	THER	OO NOT use ret.	ired)		PSYCHOLOG:	I CAL
2 should be filed withir and Mental Hygiene. Is marked other than aumatic event, the Ma	To Be (	17. Father's Name (First, Middle, Last) THEODORE	FIERSTEIN			18. Mother's N	ame (First, Middle, N		INSTEIN
d 2 sho th and h i7 is ma trauma		19a. Informant's Name/Relationship (7 JENNIFER GOLDSZMI				et and Number or I		City or Town, State, 2	
of Health of Health if Item 27 or other tra		20a. Method of Disposition 1  ☐ Burial 2 ☐ Cremation 3 ☐	20b.	Place of Dispo	sition (Name of	place)	Date 2	MD 21217 Oc. Location - City or	Town, State
Part Tr		4 Donation 5 □ Other (Specify  21. Signature of Funeral Service Licen:	AINS				0/30/2006	BALTIIMOF	•
Departr Departr Imports any inje		) Mars Cen		89	000 REIS	STERSTOWN	OL LEVINSO ROAD - PI	N & BROS., KESVILLE.	, INC. MD 21208
		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final	lications that caused the de- ine cause on each line.	ath. Do not ent	1 1 1 1 1				Approximate Interval Between Onset and Death
Physician Medical/		disease or condition resulting in death)	a. Due to (or as a conse	equence of):	puu	rifice Jo	levo 6	2	7/year
Examiner	e	Sequentially list conditions.	b	4)					0
outed nd ansit	Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a conse	equence or):					
cate be executed physician and the burial-transit	dical Exa	resulting in death) Last	Due to (or as a conse	equence of):					
entificat ding physe as th	Medi	IF FEMALE:	20-14						
The law requires that the death certific ate has been signed by the attending p age 2 should be detached for use as	Physiclan/Me	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of preging 1 ☐ Live birth 2 ☐ Feromer 4 ☐ Pregnant at time of 9 ☐ Unknown	tal death 3	Ectopic pregnar Other (specify)	ncy		23d. Date of del Month	ivery Day Year
w requires that been signed t should be det	by	Part II. Other significant conditions co	ntributing to death but not re	esulting in the ur	nderlying cause	given in Part I.		acco use contribute to	the cause of death?
	Completed						24a. Was an autopsy perform	ed? prior to death?	topsy findings available completion of cause of
icien: T certificat rector, pa	Be (	25. Was case referred to medical examiner?				26. Place of D	ath (Check only one		
Physicien: this certific ral director,	2	1 ☐ Yes 2 ☑ No		☐ ER/Outpatien	3□ DOA	Other: 4 Nursing	Home 5 ☐ Resider	nce 6 □Other (Spec	cify)
te fi	ation:	27. Manner of Death  1	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. In W	juryat /ork? □Yes 2 □No	28d. Describe how	v injury occurred	
To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At building, etc. (Spec	home, farm, stre hify)	eet, factory, offic	е	28f. Location (Street) City or Town,	eet and Number or Ru State)	ral Route Number,
Hospi 24 hou Funer etely fill	edical	29a. Certifier 1 Certifying Phy (Check orthy one) 2 Medical Exam	sician: To the best of my kr ner: On the basis of examin and manner stated.	nowledge, death nation and/or inv	occurred at the estigation, in my	time, date and place opinion, death occ	ce, and due to the car curred at the time, da	use(s) and manner as te and place, and due	stated. to the cause(s)
of the	Me	29b. Signature and title of certifier	and the state of		29c. Lice	nse number	29	d. Date signed (Monti	n, Day, Year)
10		> Mer an	1.ms						hore
1 1		30. Name and address of person who c	ompleted cause of death (Ite	ern 23a) (Type,	Print)	1 1	0.1	0 011	h: 11
t '	1	(panil All	CAAL OL	13(1	Willa	line co-	re un	e gay	100400

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day 9:50 AM **Physician** attic GRan 0 10 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Gilchrist Towson
If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Year) Months Days Hours Min 1 M 2 X F Yrs. 239-36-4164 80 03/23/1926 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show r 28a-f show notified at 1 ☐ Yes 2 No Director MD Dundalk 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or 31323 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 14. Bace - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 🗷 No Specify. ģ Specify: Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b, Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than 'amy Injury or other traumatic event, the Meonce. College (1-4or 5+) tome maker Grade )omestic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Cliver Fowler illie ပ Tinsley 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Le Grand (Husband) Rd Turners N. Avendale Station hobert W/ 31333 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11/02/04 Bathmore, MD ARbutus 22. Name and Address of Facility
Caughy C. Greene
5151 Bate North 21. Signature of Funeral Service Licenses Funeral SVC Vaughin Nati Pike, Baltimore, MD reene 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) cardiovascular was **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the death certificate be executed and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 ☐Live birth 3 ☐ Ectopic pregnancy Month Dav in the past 12 months? 1 ☐ Yes 2 No Year 4☐Pregnant at time of death 5 Other (specify) ed by the 9□Unknown 9 Unknown signed | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð pe 1 ☐ Yes 2 ☐ No 3 ☐ Probably Cunknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has page 2 autopsy performed? Yes 2000No certificate 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 1 ☐ Yes 2 ☐ No 27. Manner of Jeath Other: 4 Nursing Home 5 Residence Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3□ DOA ဥ this within 24 hours after death.

To the Funeral Director: After th completely filled in by the funeral 28b. Time of 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural 2 Accident (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier 🕊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29c License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2006

State Registrar

31. Date filed (Month, Day, Year)

31

Faulkner MD. 32. Registrar's Signature 2944

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2006

6601 N. Charles Street / Balto MD

### Please Type or Print in Black Indelible Ink

State of Maryland / Department of Health and Mental Hygiene Ronald Lewis 1- For State Certificate of Death Reg. No Registrar Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day October 25, 2006 Ronald Andrew Lewis Medical Examine 1643 hrs 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Mercy Medical Center Raltimore 5 Social Security Number If Under 1 Year If Under 24Hrs 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 6 Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Nov 29 1961 Director 215-74-1501  $_{1}X_{M}$ Country) 2 Usual Residence of Decedent 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits any Randallstown Md Baltimore 1 Yes 2 X No 28a-f show or items 23a or 28a-f shor must be notified at once. hours after death with the Maryland 10e Street and Number 10f. Zip Code 10g. Citizen of What Country USA 21133 3913 Shenton Road Funeral 11 Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian, Black, 1 Never Married 2 X Married Armed Forces? White etc 2X No Yes <sub>Specify:</sub> white 2 X No specify f Yes. Give Year "natural". <u>ج</u> 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) 16b Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+ marked other than " installation project manager security Baltimore, MD 21215-0036 18 Mother's Name (First, Middle, Maiden Surname)
Thelma Coombs 17. Father's Name (First, Middle, Last) Denvil Lewis Be 19b Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a Informant's Name/Relationship (Type, Print ) 3913 Shenton Rd., Randallstown, MD 21133 Mrs. Sandra Lewis (spouse) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State uportant: If i, Metro Crematory 1 Burial 2 X Cremation 3 Removal from State 10-30-06 Catonsville, Md 4 Donation 5 Other Specify: 22. Name and Address of Facility Haight Tunera Tome & Clapel 21. Signature of Funeral Service Licensee Page Harget Herbert P.O. Box 195 Sykesville, MD 21784 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** failure List only one cause on each line Between Onset and /Medical Death a Complications of renal cell carcinoma and cirrhosis Immediate Cause (Final disease Examine or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Examiner Due to (or as a consequence of) (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last and Physician/Medical physician a the burial -UNPENDED AMENDED Box 68760, IF FEMALE 23c. If ves, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant in the 3 Ectopic pregnancy Live birth Fetal death Month Day Year 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. ð Yes 2 V No 3 Probably 4 Unknown hypertension, obesity Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? 1 🗸 Yes ✓ Yes 2 2 No To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be Other<sub>4</sub> Hospital: 1 / Inpatient 2 FR/Outpatient 3 Nursing Home 5 Residence 6 After this 1 V Yes ဥ 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28d Describe how injury occurred Certification: 1 V Natural 1 Yes 2 No 5 Pending 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 6 Could not be Suicide or Town, State) within 24 hours a To the Funeral L determined Homicide 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started Medical (Check only 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d Date signed (Month, Day, Year) 29b Signature and title of certifie 29c. License number O.C.M.E October 26, 2006 30. Name and add of person who completed cause of death (Item 23a) Pamela E. Southall, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 32 Registrar's Signature State 1200 10 All 100 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Francis C. Lilley 6:02 AM 10 29 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Gilchrist Center Towson Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7/27/1923 7. Age (In vrs. last birthday) 5. Social Security Number 6 Sex Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 83 213-26-5434 Maryland Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City. Town or Location 10a. State 10d. Inside City Limits r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at Month Yes 2 □ No Baltimore Director MD Baltimore 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 3724 Glenmore Ave. 21206 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? ★★es 2 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian 11. Marital Status Black, White, etc. 1 □ Never Married 2 X Married 1 □ Yes ŽŽNo Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: Specify. Specify: à White 3 ☐ Widowed 4 ☐ Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Maryland Port Authority permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygierian important: if item 27 is marked other than any injury or other traumath. Elementary/Secondary (0-12) College (1-4or 5+) Police Officer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) John M. Lilley Mary Emma Dempsey 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Helen L. Lilley 3724 Glenmore Ave. Baltimore, MD 21206 October 31, 2006 20b Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Dullarne Valley ₩₩Burial 2 Cremation 3 Removal from State Memorial Gardens 4 ☐ Donation 5 ☐ Other (Specify) Timonium, MD 8800 Harford Rd. Parkville, M21234 21. Signature of Furreral Service Lice 5-10 22. Name and Address of Facility
Evans Funeral Chapel
and Cremation Services Approximate Interval Between Onset and Death 23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Physician mist disease or condition resulting in death) an /Medical Due to (or as a consequence of): Examiner Sease ean Winn Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed burial-tran Due to (or as a consequence of) or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical as IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Tyes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autonsy perform 1 ☐ Yes 2 ☐ No 2 ☑ No 25. Was case referred to medical examiner? director. 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 10.0 Medical Certification: To this funeral ( 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After or Attending 1 Natural 5 Pending investigation To the Hospital or Attendil within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No death. 2 Accident 6 ☐ Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1-Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N. Chowle It. 6701

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

3 1 2006

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Arthur Joseph Lackey Month **Physician** 10/27/06 10:25am /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Towson, MD Gilchrist Hospice Center If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year 05/31/42 Birthplace (State or Foreign Country) **Funeral** Days Hours 220-3809851 64 tv∑vM 2□F MD Director Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10a. State 1 Yes 2 □ No Adams New Oxford Director PA 10e Street and Number 10f. Zip Code 10g, Citizen of What Country? 17350 USA 500 N. Bolton Street Funeral 12. Was Decedent Ever in U.S. Armed Forces? . Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specity Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 📉 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2**X** X o Specify white ģ Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 10 0 <u>Maintenance Man</u> Police Dept ulth and Mental Hv 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Viola Rosafeldt John A. Lackey ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Daughter 516 Carrollwood Rd Apt-C Middle River MD Ashley R. Lackey / 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Lorraine Cem 10/30/2006 Baltimore MD 4 ☐ Donation 5 ☐ Other (Specify) Doda 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Victor P. Charles L. Stevens Funeral Home, Inc 1501 E. Fort Ave, Baltimore MD 21230 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (of)s a consequence of): cellular corcinana **Physician** minters /Medical **Examiner** Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to or as a consequence of Examir be executed burial-trar Due to (or as a consequence of): attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the detached 9∏Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 | Yes 2 | No 3 | Probably 4 | Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform rmed? 2 No To the Hospital or Attending Physician: within 24 hours after death.

o the Funeral Director; After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 20100 Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 DOA P 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 025205 October 27, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6701 N. duls St. Balto, M. 21207 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

Baltimore, Maryland 21215-0036

Box 68760.

P.O.

Records,

Division or Vital

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Vear **Physician** 12:43 AM LUZ21 AR MANDO CTOBER 28 2006 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner HOSPITAL BALTIMOR N/A SAMARITAN If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth March 27, 1924 Birthplace (State or March 27, 1924 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** 1 M 2 □ F 218-28-8534 Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b County 10a State "natural", or items 23a or 28a-f show adical Examiner must be notified at 1√ Yes 2 No N/A Baltimore Director Md. 10g. Citizen of What Country? 10e. Street and Number 10f Zip Code 21239 6401 Loch Raven Blvd. Apt 206 USA permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: if Item 27 is marked other then "natural", or Items 23e eny injury or other traumatic event, the Madical Examinar must once. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Specify: White þ 3 ☐ Widowed 4 X Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Travel Travel Agent 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Gesualdo Luzzi Larina Adele Casseri 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1026 N. Re Dondo Ave. Manhattan Beach, Ca. 90266 Larina Luzzi/ Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 □ Burial 2 Cremation 3 □ Removal from State Hilltop Service Co. 11-1-06 Towson, Md. 4 □Donation 5 □ Other (Specify) 22. Name and Address of Facility
RUSK TOWSON TOWSON, MG: 11204 21. Signature of Foneral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final SEPSI **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) ed by the a detached f 9 Unknown been signed by should be detact Part If, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ INSUFFICIENCY 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No page 2 s certificete 1 Yes 2 XNo 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No 2 Accident investigation Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours af To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifiei Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Bahl D0058 412 OCTOBER 30 2806 Namusha 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5601 LOCH RAVEN BOULEVARD 6 , MD BALTIMORE, MARYLAND MANISHA BAHL 31. Date filed (Month, Day, Year) 32. Registrar's Signature 1 2006 dosell State MERLES. Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] [] 5 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 12:15A <sup>™</sup> October 2006 \_J. Virginia Liberto 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Baltimore Keswick Multicare Center Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) May 13, 19 7. Age (In yrs. last birthday) 5. Social Security Number Days 1 ☐ M 2 🖾 F Yrs. NB 1913 93 212-01-3346 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2√☐ No Reisterstown Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21136 USA 25 Glyndon Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 📉 No Specify: 3 ₩ Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Own Home Housewife 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) unknown Frances Pepitone 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 25 Glyndon Drive, Reisterstown, MD 21136 Son Samuel A. Liberto 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Druid Ridge Cemetery 10/31/06 Pikesville, MD `4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 11824 Reisterstown Road Eline Funeral Home Reisterstown, MD 21136 ine 23a. art i. Enter the disease, or complications that caused the death. Do not enter the made of dying, such as cardiac or respiratory arrest, shirck, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Im soliate Cause (Final discase or condition resulting in death) years Due to (or as a consequence of):

Pnysician /Medical Examiner For State Registrar

10a, State

12

Joseph

Be Completed by Funeral Director

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**Physician** 

/Medical

Examiner

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f ahow any injury or other traumatic avant, the Madical Ferminance or other traumatic avant.

physician and s the burial-transit To the Hospital or Attanding Physician: within 24 hours after death. To the Funaral Director: After this certifica

The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

rial-transit	Medical Certification; To Be Completed by Physician/Medical Examiner	
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completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician	
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Sequentially list conditions, if any leadin, to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of):  Due to (or as a consequence of):	57 0 11		J
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1	s pregnancy (specify)		23d. Date of delivery Month Day Year
Part II. Other significant conditions co	ntributing to death but not resulting in the underlying	g cause given in Part I.	23e. Did tobacco	use contribute to the cause of death?
COVOMANY 1	Hery desease	>	1 ☐ Yes 2	No 3 Probably 4 Unknown
Hypn Cipi Disease		ic Kidney	autopsy	24b. Were autopsy findings available prior to completion of cause of death?  1  Yes 2 No
25. Was case referred to medical examiner?			th (Check only one)	
1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐	DOA Other: 4 Nursing Ho	ome 5 Residence	6 ☐Other (Specify)
27. Manner of Death 1 ☑ Natural 5 ☑ Pending 2 ☑ Accident investigation	28a. Date of Injury (Month, Day Year)  28b. Time of Injury  M	28c. Injury at Work? 1  Yes 2  No	28d. Describe how inju	ury occurred
3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, street, fact building, etc. (Specify)	tory, office	28f. Location (Street a City or Town, Stat	nd Number or Rural Route Number, e)
29a. Certifier Certifying Phy (Check only one)	rsician: To the best of my knowledge, death occurr iner: On the basis of examination and/or investigat and manner stated.	red at the time, date and place, ion, in my opinion, death occur	and due to the cause(stred at the time, date ar	s) and manner as stated. Id place, and due to the cause(s)
29b. Signature and title of certifier		29c. License number	29d. D	ate signed (Month, Day, Year)
> Il Anto	my Kily mis	025205	00	tober 27, 2006
30. Name and address of person who o	ompleted cause of death (Item 23a) (Type, Print)	SI N. Ch	als SI	Balto. Md Zi zage

State Registrar

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

ORIGINAL

32. Registrar's Signature

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician GERTRUDE OCTOBER** 27 LEVINE 2006 9:35 P /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner HOSPICE OF BALTIMORE GILCHRIST CTR. TOWSON BALTIMORE 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex **Funeral** Months Days Hours 1 □ M 2 □ F Director 82 219-10-0849 07/14/1924 MD Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits MD BALTIMORE BALTIMORE 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 14 STONEHENGE CIRCLE APT. #1 21208 by Funeral U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give X 14. Bace - American Indian 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No WHITE Specify 3 ☐ Widowed 4 ☐ Divorced ear or Dates Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15 Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) 12 HOMEMAKER OWN\_HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be FRANK GREENSTEIN BESSIE WEINER 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CARYN PLAINE / DAUGHTER 3201 WOODVALLEY DRIVE - BALTIMORE, MD 21208 20a, Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) MIKRO KODESH BETH 10/29/2006 BALTIMORE, MD ISRAEL CONC. and Address of Facility 21. Signature of Funeral Service Licensee SOL LEVINSON & BROS., INC. 23a. Part1. Enter the disease, or complications that caused the death. Shock, or heart failure. List only one cause on each line. Immediate Cause (Final ANCER with netastaces **Physician** resulting in death) /Medical Due to (or as a consequence of) Examiner Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 4□Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 9 Unknown 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably Cunknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No autonsy performed? Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Nother (Specify) No S 2 1 ☐ Yes 1 🔲 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Seath Natural 2 Accident 28a. Date of Injury 28h. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) Injury 5 Pending investigation 1 Yes 2 No

death certificate be executed Division or Vital Records, P.O. Box 68760,

sician and burial-transit attending physician for use as the buria ned by the and detached for signed I been si has

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Baltimore, Maryland 21215-0036

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Attending Physician: Hospital or Attending Phy. 4 hours after death. Funeral Director: After this tely filled in by the funeral di

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print) lendall R State Registrar

Medical

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

3 ☐ Suicide

29a. Certifier

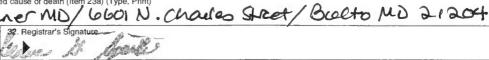
4 ☐ Homicide

6 ☐ Could not be

determined

2006

3 1



28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

			For State Registrar	State of Marylan	d / Dep <i>Ce</i>	artment of He <i>rtificate of E</i>	ealth and N Death		ien <b>2</b> 0 0 6	34517
	Physicia /Medic		1. Decedent's Name (First, Middle, La  William	Mielke				2. Date of Deat Month	Day Year	3. Time of Death 7, 25 AM
	Examin		4a. Facility Name (If not institution, given Charlestown Reti	,		4b. City, Town, or Catonsvil			4c. County of Dea Baltimore	
	Funeral Director		5. Social Security Number 6. S 213-03-8600	Sex 7. Age (In yrs. 11	last birthday, Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, March 2	Year) 9. Bi	rthplace (State or Foreign ountry)
	pug 🛦		Usual Residence of Decedent  10a. State 10b. County	10c Cit	y, Town or L	ocation				10d. Inside City Limits
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	r 28a	Director	10e. Street and Number			10f. Zip Code		10	0g. Citizen of What C	ountry?
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2-0036	72 hours after death with the Maryland naturel; or iteme 23a or 28a-f ehow alcal Examinant to notified a	by Funeral	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U.S. Armed Forces?  1 □ Yes 2 ☑ No If Yes, Give ⚠ Year or Dates:		Was Decedent of His If Yes, specify Cubar 1 ☐ Yes 2 ☐ Mo	spanic Origin? (Sp n, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Wh Specify:	
0-6171	nit. Peges 1 and 2 should be filed within 72 hours after death with the Marylan ortanent of Health and Mental Hygiene. ortanent of Health and Mental Hygiene. ortanent: if tier may 7 is marked other than "naturel; or iteme 23a or 28a-1 show injury or other traumatic event, in Medical Exactions must be notified as injury or other traumatic event, in Medical Exactions must be notified as 9.	Completed	15. Decedent's E (Specify only highest gr.	Education grade completed)  College (1-4or 5+)		dent's Usual Occupa e kind of work done di DO NOT use retired) 1gineer	ition luring most of work )	sing	16b. Kind of Business Oil Comp	·
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TI III OL	t. Peges tment of it tent: if it ijury or o		1 Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special Control of the Contro	Removal from State Lak	emetery, cre e Viev	matory or other place v Mem Park	11/2	/06	Sykesville	e, MD
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	Physician /Medical Examiner	Examiner	23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enier underlying Cause (Disease or injury that initiated events	a. Myelo-d Due to (or as a conseq	unce of):	Jania.	, such as cardiac	or respiratory arre	ist,	Approximate Interval Between Onset and Death
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ras, r	w requires that the di been signed by the should be deteched	þ	Part II. Other significant conditions Demen fix	contributing to death but not res	ulting in the i	underlying cause give	n in Part I.		101 102	to the cause of death?
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Division of	nding Phy th. : After this s funeral d	l Hall	1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	of 28c. Injury Work	4 Nursing H	ome 5 ☐ Reside 28d. Describe ho	nce 6 Other (Spow injury occurred	ecify)
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	To 1 To 1	Σ	29b. Signature and title of certifier	0 0		29c. License			9d. Date signed (Mon	
	1		30. Name and address of person who	Benler,	us	DYY	1377	3- 4- 14	10/30/1	96
	{e		30. Name and address of person who HI Maiden Che	completed cause of death (Item	1 23a) (Type	Print) Denec	mn 2	in wib		
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Signa	iture	horal s	1100 0	000		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2006 34518 Certificate of Death Rag. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death October 31, 2006 **Physician** 1:10A M Douglas Mitchel /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Doctor's Community Hospital Lanham P.G. If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day Year) 2/27/18 **Funeral** 9. Birthplace (State or Foreign Months 1 ★M 2 ☐ F 579-05-2888 88 Yrs. Director Washington, PC Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other then "naturel", or iteme 23a or 28a-f ebo other treumetic avent, the Mudical Exercit at must be notified at 1 Yes 2 No Directo MD P.G. Seabrook 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 9903 Santa Cruz Street 20706 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Payes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 No þ Specify: 3 XWidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) **8th** 1 and 2 should be filed withir Heelth and Mental Hygiene. em 27 Is markad other then College (1-4or 5+) Inspector Dc Gov't 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be unknown Myrtle Limerick 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Depertment of Heelth ar Importent: if item 27 Is any Injury or other treu <u>2005</u>. Gina Parnell-Daughter 9903 Santa Cruz St. Seabrook, MD 20706 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 □ Cremation 3 □ Removal from State Ft. Lincoln 10/25/06 Brentwood, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur of Funeral Service Licenses Brentwood MD 22. Name and Address of Facility Ft. Lincoln FH 3401 Bladensburg Rd. 20722 23a. Part Enter the disease, or communications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final HYPERTENSIVE ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE Physician 20445 disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner anding physicien and use as the burial-transit Due to (or as a consequence of): Physician/Medical attending for use as IF FEMALE: 23c. tf yes, outcome of pregnancy 1 Live birth 2 Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4☐ Pregnant at time of death 9☐ Unknown Month Day Year 5 Other (specify) ed by the a 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ cete hes been sign, pege 2 should be 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificete hes funeral director, pege 2: autopsy performed 1 Yes 2 No 1 Yes 2 No Be ( 25. Was case referred to medicat 26. Place of Death (Check only one) examiner?
1 Yes 2 No Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manger of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending after death.

3 Director: After the further the furthe 1 Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a
To the Funeral D
completely filled i 10 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signaring and title of certified 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
WILLIAM D. ROSSON, MD. 5701 85th AVE, NEW CARROLLTON, MARYLAND, 20785 WILLIAM D. ROSSON, MD. 5701

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year) OCT 3

32. Registrar's Signature

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** 29,2006 0:16 AM LYNN MORGAN DEANNA Octobe /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Union Memorial Hospital 8. Date of Birth April 1 27, 1970 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. 36 Maryland 217-86-5881 Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show item 27 is marked other than "natural", or Items 23a or 28a-f shov other traumatic event, the Medical Examiner must be notified at Baltimore 1 ☐ Yes 2 No MD Baltimore Director 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or Items 23a or 21236 8508 Gradien Drive USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2X If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No White Specify. Specify: þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Landscaping Self Employed 9 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pauline Danny A. Shakra J. Morgan ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 i Pauline J. Shakra-mother 8508 Gradien Drive-Baltimore, Maryland 21236 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State Department of H Important: If its any injury or ot once. Gardens Of Faith 11-2-06 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Rosedale , Maryland 4 ☐ Donation 5 ☐ Other (Specify) Cemetery 22. Name and Address of Facility EVANS FUNERAL CHAPEL AND CREMATION SERVICE 21. Signature of Funeral Service Licensee 8800 Harford Road Parkville Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Week Due t docar Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner physician and Due to (or as a consequence of) Physician/Medical the IF FEMALE 23d. Date of delivery egnancy Month Year Day ecify) ause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed

Physician /Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed

the Maryland

Baltimore, Maryland 21215-0036

within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, Be Certification: To Medical

Division or Vital Records, P.O. Box 68760

23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome pf p 1 □ Live birth 2 □ 4 □ Pregnant at tim 9 □ Unknown	∃Fetal death 3 ⊟E	Ectopic pr Other (sp
Part II. Other significant condition	s contributing to death but n	ot resulting in the und	lerlying ca
25. Was case referred to medical examiner?  1 □ Yes 2 1	Hospital: 12 Innation	2□FR/Outpatient	

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	Was autop perfo Yes	sy rmed	!? No	24b.	Were aut prior to c death? 1 ☐ Yes	omple	tion o	gs ava	ilable e of
ı									

25. Was case referred to medical		26. Place of Death (Check only one)								
examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 Inpatient 2	lospital: 1 Inpatient 2 ☐ ER/Outpatient			lome 5 ☐ Residence 6 ☐ Other (Specify)					
27. Manner of Death 1 ☐ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c.	Injury at Work?	28d. Describe how injury occurred					
2 Assident investigation	n i i i i i i i i i i i i i i i i i i i		M	1 ☐ Yes 2 ☐ No						

1 ☐ Natural 2 ☐ Accident	5 Pending investigation	(Month, Day Year)	Injury M	Work? 1 ☐ Yes	2 □No	
3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could not be determined	28e. Place of injury - At hon building, etc. (Specify)	ne, farm, street, facto	ory, office		28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier	1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	
(Check only	2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ca	ause(
one)	and manner stated.	

(Check only one) 4 Medical Examiner: On the basis of examination and/or investigation one)		
29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
· Dielin	AT 2436946	October 29 2006

- Lilly	
30. Name and address of person who	completed cause of death (Item 23a) (Type, Print)

30, Name and address of person who complete	ed cause of death (item 23a) (Type, Fi	((IL)		,	
Gere D. Feltus	SIMD	Union	Memorial	Hospital	. MD
31. Date filed (Month, Day, Year)	32. Registrar's Signature -			-7	, ,

State Registrar



within 24 hours a

### Please Type or Print in Black Indelible Ink

Gertrude Mitchell	State of Maryland / Department of Health and Mental Hyg  1- For State Registrar  Certificate of Death	Reg. No. 2006 34521
Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last)	Date of Death   3 Time of Death   Month   Day   Year   1754 hrs
	4a Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death University Hospital  Baltimore	4c. County of Death
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8 Months Days Hours Min.	B Date of Birth (MM/DD/YYYY) Birthplace (State or Foreign North Country)
any	Usual Residence of Decedent  10a State 10b. County 10c. City. Town or Location	10d Inside City Limits
·land -f show once.	Md. N/A Baltimore	1 X Yes 2 No
h the Mar 3a or 28a lotified at	10e. Street and Number 10f. Zip Code 2/206	10g. Citizen of What Country? USA
r death with the Marylan, or items 23a or 28a-f strongs the notified at one Funest he notified at one Funeral Director	11. Marital Status 1 Never Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No	can, etc.) White, etc.
nours afte	3 Vildowed 4 Divorced in res. Give rear or Dates:	
5-0036 ed within 72 hour bygiene. other than "natu the Medical Exan Completed	Elementary/Secondary (0-12)  College (1-4 or 5+)  Cafeteria Work  17. Father's Name (First, Middle, Last)	er Balto. City P. S.
2121 did be fil Mental F warked event, I	Ernest Mitchell Millie	Richard Stokes
, MD 2 and 2 shou ealth and 1 em 27 is -	Mr. Clarence Mitchell 15200 Bowleys La	ane Balto, Md. 2/206 Pate 20c. Location - City or Town, State
imore Pages   2 ment of H tant: If it or other 1	1 X Burial 2 Cremation 3 Removal from State Arbitus Mein, Park 11/4/	2006 Balto, Md.
	21 Signature of Funeral Service Licensee  22. Name and Address of Facility  Joseph L. Russ Fur  22. ZZZW, North Ave.	Parto, Md. 21216
Physician /Medical *xaminer	23a Part I. Enter the disease, or combilications that caused the death. Do not enter the mode of dying, such as cardiac or re allure. List dyly one cause on each line.  Immediate Cause (Final disease a Multiple Injuries	Approximate Interval Between Onset and Death
Administra	or condition resulting in death)  Due to (or as a consequence of):  Sequentially list conditions,  b.	
ted Insit Examiner	if any, leading to immediate  cause Enter Underlying Cause (Disease or injury that illulated events resulting in death) Last  events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):	
ecuted and ransit	events resulting in death) Last Due to (or as a consequence of):	
60, ate be execu ohysician and te burial - tra	UNPENDED AMENDED  IF FEMALE: 23c. If yes, outcome of pregnancy	23d Date of delivery
box 68760, the death certificate be executed by the attending physician and ched for use as the burial - transit Physician/Medical Ex	23b. Was decedent pregnant in the past 12 months?  1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (Specify)	y Month Day Year
b. Bo the deat by the at ched for	1 Yes 2 ✓ No 9 Unknown 9 Unknown  Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?
b, P.O. irres that the signed by d be detach		1 Yes 2 No 3 Probably 4 Unknown
Records, The law requires frate has been sig		24a Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?
tal Reco		1 Yes 2 No 1 Yes 2 No
Vital hysician this certi		Home 5 Residence 6 Other:
Division of Vital Records, P.O. B pital or Attending Physician: The law requires that the d ours after death.  reral Director: After this certificate has been signed by the filled in by the funeral director, page 2 should be detached Certification: To Be Completed by Phy		ld Describe how injury occurred assenger auto auto collision
Division c spital or Attending fours after death. ureral Director: At filled in by the fun Certification	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify) Local Street  (Specify) Local Street	ff. Location (Street and Number or Rural Route Number, City or Town, State)
X = 3 × 0		
To the He within 24 To the Fu completel	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the and manner stated  29b. Signature and title of certifier  29c. License number	29d. Date signed (Month, Day, Year)
	Josha Jean ins O.C.M.E.	October 30, 2006
10	30. Name and address of person who completed caluse of death (Item 23a)  Tasha Greenberg MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 2	21201
State	31. Date filed (Month, Day, Year) 32. Reflistrar's Signature	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 2006 **JEAN SCHWARZKOPFT** MOXLEY October 28, 4:45P /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner N/A The Wesley Baltimore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day Year) | Min. | May 1, 1921 9. Birthplace (State or Foreign Country)
Maryland 5. Social Security Number 7. Age (In yrs. last birthday) 1 □ M 2/1/F 216-12-3147 Yrs Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a State 1, Yes 2 No Funeral Director Maryland N/A Baltimore 10g. Citizen of What Country? 10f Zin Code 10e. Street and Number 2211 West Rogers Avenue 21209 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes A N No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 Yes 2 10 No Specify: Specify: White δ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Registered Nurse 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Gerard Joseph Schwarzkopft Marie Mary Heying 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Bonnie S Jaeger DTR 103 Beech Bark Lane Towson, Maryland 21286 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition

✓ MBurial 2 □ Cremation 3 □ Removal from State St Mary's Cemetery 11/2/06 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home Inc 21. Signature of Funeral Sérvice Licensee 6500 York Road Baltimore, Maryland 21212 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) DEMENTIA END- STAGE CARS Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter uncertying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month in the past 12 months? 1 ☐ Yes 2 No 4☐Pregnant at time of death 5 ☐ Other (specify) 9☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 ☐ Probably 4 ☐Unknown 1 ☐ Yes 2 XNo Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 🗆 No 1 ☐ Yes 1 Tyes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

Priysician /Medical Examiner P.O. Box 68760, Division of Vital Records,

**Funeral** 

Director

rel', or Items 23a or 28e-f show Examiner must be notified at

"naturel"

permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked othe any injury or other treumatic event, 2008.

Maryland 21215-0036

Baltimore,

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death. Director: To the Hospitel within 24 hours a To the Funerel C

filled in by

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ROBY

29b. Signature and title of certifier

W. ROGERS AVE-

LEcertifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Dey, Year)

E. 32 Registrar's Signature 31. Date filed (Month, Day, Year) OCT 3 1 2006

Baltimore, Maryland 21215-0036

OCTOBER 26, 2006 5:40 a.m.

Division of Vital Records, P.O. Box 68760, © AUGUST MCCOLGAN

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Physicia	ın		T. McColga	in Sr			Oct. 26,	2006 Year	5:40	Ам
/Medic		4a. Facility Name (If not institution,	<u>~</u> _		4h City Town	or Location of Death	000. 20,	4c. County of Death		
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Funeral				je (In yrs. last birti		If Under 24 Hrs. Hours Min.	8. Date of Birth	9. Birth	place (State or	Foreign
Director		212-09-0396	1920 Mary	land						
p .		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town	or Location				10d. Inside City	y t imite
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the N	Director	Md. Ba	1timore		1 1 TTC	onium	100	g. Citizen of What Cou		
rs after death with the Marylan ", or iteme 23s or 28s-1 show saminer mail be notified at	흐	2525 Pot Spri	ng Road 16	514	101. Zip 0008	21093	1,0	USA	muy:	
me 23	Funeral	11. Marital Status	12. Was Decedent	Ever in U.S.	13. Was Decedent of I ff Yes, specify Cub		ecify Yes or No-	14. Race - Amer		
or ite	Ē	1 Never Married 2 Marrie	Armed Forces' d 1 XYes 2 1 ff Yes, Give	°N∘1943-	1 Yes, specify Cub		Hican, etc.)	Black, White	, etc.	
궁 존때	d by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:	1963				Specify: W	hite	
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id be ental ked c	To Be	Arthur	P. McCold	ıan		Fr	ances C	atanzaro		
shou and M mer	-	19a. Informant's Name/Relationshi			Mailing Address (Street	·			p Code)	
permit. Pages 1 and 2 should be filed within 72 ho Department of Heath and Mental Hygiene. Important: If Item 27 is marked other than "naturany injury or other traumatic event, the Medical one.		Mrs. Mary E. McC	olgan/Wife	252	5 Pot Sprin	ng Rd. L61	4 Timoni	um, Md. 21	093	
of He of He fiten		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3	I Plemoval from State		Disposition (Name of y, crematory or other pla	ice)	Date 2	oc. Location - City or 1	own, State	
Pag ment ant: f ury o		4 Donation 5 Other (Spe		Dulaney	Valley Men	n. Grd. 10	/30/06 T	imonium, M	aryland	1
permit. Depart Import any inj		21. Signature of Funeral Service Li	censee	0/				Funeral H		IC.
205 g g		Molace	A True	31	1050 York			ryland 212		
		23a. Part1. Enter the disease, or c shock, or heart failure. List or	omplications that cause nly one cause on each i	ine.	ot enter the mode of dyl	ng, such as cardiac	or respiratory arres	st,	Approximate Interval Betw Onset and D	veen
Physician /Medical		Immediate Cause (Final disease or condition resulting in death)		CT CARCI						
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te be executed ysician and te burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events								
exec an an rial-tr		resulting in death) Last	Due to (or as	a consequence o	of):					
Attanding Physician: The law requires that the death certificate be executed in death. •ctor: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit	ca		d							
leath certificate attending phy	by Physician/Medi	IF FEMALE:	23c. If yes, outcome							
ath ce	lan/	23b. Was decedent pregnant in the past 12 months?		23d. Date of delivery  Month Day Year						
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The la e has age 2	Completed						autopsy perform	prior to c death?	ompletion of ca	use of
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nysici iis cer direc	To B	examiner? 1 ☐ Yes 2 👿 No	Hospital: 1 📋 Inpati	ient 2 ER/Out	tpatient 3☐ DOA Ot	her: 4 🗍 Nursing Ho	me 5 🗋 Residen	ce 6 X Other (Spec	fy) HOSP	1CE
ng Pt fter th neral		27. Manner of Death 1 XNatural 5 ☐ Pending	28a. Date of Inj (Month, Da		ime of 28c. Injury Wo	ry at	28d. Describe how	rinjury occurred		
tendi eath. or: A	catle	2 Accident investiga	tion			]Yes 2 ☐No				
or Att	Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	ad 289. Place of in	ijury - At home, fai tc. <i>(Specify)</i>	m, street, factory, office		28f. Location (Stre City or Town,	eet and Number or Ru. State)	rai Route Numb	) <i>91</i> ,
pitai ours a erai f		28s Cartifier 1X Certifying	Physician: To the bas	of our fermated as	funtly concerned at the t	one data and plans	Tool chira to the en-	entel and various as	etuta.	
To the Hospital or Attending Physician: The law requires that the de within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached	edical	(Check only 2 Medical E.	xaminer: On the basis and manner s	of examination and	Vor investigation, in my	opinion, death occur	red at the time, dat	e and place, and due	to the cause(s)	
To th To th comp	Me	29b. Signature and title of certifier			29c. Licen			d. Date signed (Month	, Day, Year)	
			/al		D	43725		10/26/	66	
2041		30. Name and address of person w	ho completed cause of	death (Item 23a) (	Type, Print)					
~		DR. TARIQ MAHMO		LANEY VA	LLEY RD. T	IMONIUM,	MD 21093			
Sta Registr		31. Date filed (Month, Day, Year)	. 107	rar's Signature	Costs					
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# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

			For State	State of Marylai					ental Hyg	giene				
	_	-	Registrar  1. Decedent's Name (First, Middle, Last)		Cer	tificate of	Death		2. Date of Dea	Reg. No.	2006	3. Time of Death.		
	Physicia		Doris Ward Micha	alek						Month Day Year				
	/Medic Examin		4a. Facility Name (If not institution, give s			4b. City, Town,	or Location of	of Death	000000	ber 25, 2006   3:00 P M   4c. County of Death				
2.			Gilchrist Hospice				wson	2411			Baltim			
	Funeral		5. Social Security Number 6. Sex 1□	7. Age (In yrs	s. last birthday) Yrs.	If Under 1 Year Months Days		Min.	8. Date of Birth (Month, Day	r, Year)	9. Birth	place (State or Foreign ntry)		
М-	Director		Usual Residence of Decedent						Sep. 22	, 191	Lo Ne	w York		
	ryland thow		10a. State 10b. County	10c. C	City, Town or Loc	ation						10d. Inside City Limits		
	he Ma Ba-f s	ecto	MD N/A		Ba	1timore						1 X Yes 2 No		
	with t laor 2 t be n	Dir	10e. Street and Number 3300 Benson Avenue	Apt 315		10f. Zip Code	21229			_	n of What Cou	•		
	ms 23	Funeral Director		12. Was Decedent Ever in U	U.S. 13. V	Vas Decedent of Yes, specify Cu		igin? (Spec	ify Yes or No-		ted Sta	can indian,		
٥	72 hours after death with the Maryland 'natural', or Items 23a or 28a-f show dical Examiner must be notified at		1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give		Yes, specify Cu			lican, etc.)	1	Black, White, pec <i>ity:</i> Whi			
3-003 <del>0</del>	ural",	d by	3 Widowed 4 □ Divorced	Year or Dates:		ent's Usual Occ								
<u>.</u>	in 72 n "nal Nedica	Completed	15. Decedent's Educ (Specify only highest grade	e completed)	(Give I	kind of work don OO NOT use reti	e during mos ed)	st of working	g	FOD. KING	of Business/Ir	adustry		
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	s 1 and 2 should be filed within 72 hours after death with the Marylan f Health and Mental Hygiene 1 feet than "natural", or items 23a or 28a-f show frem 21 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		19a. Informant's Name/Relationship (Type Patti Amsel - Daug			g Address <i>(Stre</i> Falls								
ē,	permit. Pages 1 and 2 Department of Health a Important: If item 27 is any Injury or other tra		20a. Method of Disposition	20b.	Place of Dispos	sition (Name of	1		ate		tion - City or T			
Ē	Page nent c ant: If ury or		1 M Burial 2 □ Cremation 3 □ R 4 □ Popation 5 □ Other (Specify)	emoval from State	cemetery cren crestlav			10-28	3-2006			ille, MD		
Бащтог	permit. Departr Importa any Inji	(	21. Signature of Funeral Service License	Month	Garde	Name and Add	ress of Facili	ity An				e, Inc.		
_	로마트ョ의	1	STANDANIA MARIANA			328 Sulp	_				ıs, MD			
			23a. Part1. Enter the disease, or compli- shock, or heart failure. List only on Immediate Cause (Final	ie cause on each line.	atti. Do not ente				respiratory ar	rest,		Approximate Interval Between Onset and Death		
	Physician /Medical		disease or condition resulting in death)	Due to (or as a conse	equence of):	df 0	emu	Mig				yers		
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٥,	sit ad	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conse	equence of):									
	icate be executed physician and s the burial-transit	хап	that initiated events resulting in death) Last	Due to (or as a conse	equence of):									
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X Q Q	ath cel tendir or use	an//	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome pf preg 1 ☐ Live birth 2 ☐ Fe	etal death 3	Ectopic pregnar				230	d. Date of deliv	,		
	ne dea the at hed fo	Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time of 9□Unknown	fdeath 5⊡	Other (specify)					MOHIT	Day Year		
	that the the the the the the the the the th	/ Ph	Part II. Other significant conditions con	ntributing to death but not re	esulting in the ur	nderlying cause	given in Part I	l.	23e. Did to	bacco use	contribute to	the cause of death?		
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ပ္သ	law re as bee 2 sho	Completed							24a. Was autop		24b. Were aut	opsy findings available ompletion of cause of		
Ť	The ate ha	Com							perfo	rmed?	death? 1 ☐ Yes	2 No		
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0	th. ; After	tion	1 Natural 5 □ Pending 2 □ Accident investigation	(Month, Day Year)		N N	ork? ☐ Yes 2 ☐		ou. Describe i	1044 IIIJULY C	Sociality			
UIVISION	r Atter	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At building, etc. (Spec	home, farm, stre cify)	eet, factory, offic	e	2:	8f. Location (S City or Tox		Number or Rui	al Route Number,		
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	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death, within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as	Medical	29a. Certifier 1 Certifying Physical (Check only one) Medical Exami	sician: To the best of my kiner: On the basis of examinand manner stated.	nowledge, death nation and/or in	n occurred at the vestigation, in m	time, date a y opinion, de	ind place, a eath occurre	and due to the ed at the time,	cause(s) ai date and p	nd manner as lace, and due	stated. to the cause(s)		
	ro the vithin го the хотрк	Med	29b. Signature and title of certifier	and marines stated.			nse number				signed (Month			
			Mach	w)		0	5830	17		OCTU	300 2	6 2006		
	4		30. Name and address of person who co	empleted cause of death (It	em 23a) (Type,	Print)	c 64	D-			7 (2 01/	6 200,6		
			31. Date filed (Month, Day, Year)	A. Registrar's Sig	1	NOVE	AUT I	180M	me!	VU)	104			
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Albert P. Mann 29 )ctober /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Union Memorial Hospital Baltimore N/A Social Security Number if Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) 9-10-1915 9. Birthplace (State or Foreign Country)
Maryland **Funeral** 213-16-3920 XXM 2 F Days Hours 91 Yrs Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examination. 10a. State 10h. County 10c. City, Town or Location 10d. Inside City Limits Maryland N/A Be Completed by Funeral Director Baltimore 1XXes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1200 Dellwood Avenue 21211 USA 12. Was Decedent Ever in U.S. Armed Forces? 11∆ Yes 2 □ No If Yes Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married If Yes, Give Year or Dates:WWII 1 ☐ Yes ŽŽÝNo Specify: white XMWidowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Chauffeur Medical Profession 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Louis Mann Alice Burkins ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gloria M. Blucher Daughter 1200 Dellwood Ave. Baltimore, MD 21211 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Varial 2 ☐ Cremation 3 ☐ Removal from State Lake View Memorial Pk 11/3 4 □ Donation 5 □ Other (Specify) Eldersburg, MD 22. Name and Address of Facility
Burgee-Henss-Seitz Funeral Home, Inc.
3631 Falls Road Baltimore, MD 21211 21. Signatu Funeral Service Livens 23a. Part I Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only ord cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician 0 50 Years /Medical Due to (or as a consequence of): Examiner OFORACY if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) Box 68760. by Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) Division or Vital Records, P.O. 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 🗹 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an death? 1 ☐ Yes 2 No 2 No 1□ Yes 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 □ DOA Certification: To 27. Manner of Death 1 ☑ Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Do053539 Cktober 29th, 2006

State Registrar

ate 31. Date filed (Month, Day, Year) CT 3 1 2006

MD Uni

30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

on Memorial Hospi

State of Maryland / Department of Health and Mental Hygiene 2006 34525 For State Registrar 1-Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** MAY, Month Year 1120 A toward ugene 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Burnie 326 Broaducew LEN 9 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 04-20-1920 Birthplace (State or Foreign Country) **Funeral** Months Days Min. 1**X** M 2□ F Hours 220-05-4346 Director 86 Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 23a or 28a-f ehow r then "natural", or items 23a or 28a-f ehove the Medical Examiner roust be notified at 1 ☐ Yes 2 No Director Glen Burnie Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1326 North Broadview Blvd. 21061 U.S.A. death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: white 1 ☐ Yes 2 No Specify þ 3₺ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 6 Machinist Westinghouse other 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Item 27 is marked oth any linjury or other treumatic event 9DRS. 18. Mother's Name (First, Middle, Maiden Sumame) Be unknown unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 101 Laurel Avenue; Glen Burnie, MD 21061 Mr. Howard E. May, Jr. /son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 4 Donation S Other (Specify) Glen Haven Mem. Park 10-30-2006 Glen Burnie, MD 21. Signature of Fineral Service L. ensee 22. Name and Address of Facility Singleton Funeral Home, PA 1 Second Ave SW; Glen Burnie, MD 21061 23a. Pan1. Enter the disease, or complications t shock, or heart failure. List only one cause complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Trterioschero /Medical Due to (or as a consequence of): Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine sician and To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Records, P.O. Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4 Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 Unknown Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 1 ☐ Yes 2 ☐ No 4 Unknown certificate has been si rector, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Division of Vital 1 Yes 2 No 1 🗌 Yes 24 hours after death.

• Funeral Director: After this certific letely filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death Check only one Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation within 24 hours after dea To the Funeral Directo completely filled in by th 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month Day Year) )epur D0605 se of death (Item 23a) (Type, Print) 30. Name and address of person who completed care DNES, wo 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar DASSE 1 2006

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Richard S. Morey 2006 October 26, 4:00 A 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 8216 Windsor View Terrace Potomac Montgomery If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year 9. Birthplace (State or Foreign Days 1 № M 2 🗆 F 155-28-6073 68 May 6, New York Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Montgomery 1 ☐ Yes 2 🔀 No Potomac 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8216 Windsor View Terrace 20854 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 X Yes 2 No 1960— If Yes, Give Year or Dates: 1963 1 ☐ Never Married 2 M Married 1 ☐ Yes 2 🔀 No Specify Specify: 3 ☐ Widowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 5+ Attorney Law 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles Morey Sophie Hillman 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Helen Morey / Wife 8216 Windsor View Terrace, Potomac, Maryland 20854 20b. Place of Disposition (Name of cemetery, crematory or other place) Parklawn 20a. Method of Disposition Date 20c. Location - City or Town, State October 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Memorial Park 30, 2006 Rockville, Maryland 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue 21. Signature of Funeral Service License Bethesda-Chevy Chase, In M01433 Bethesda, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Biliary Tract Cancer months Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2X No 2∏ No 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 ☐ Nursing Home 5 🖾 Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 X Natural Injury

Examine burial-transi The law requires that the death certificate be executed and P.O. Box 68760. physician Physician/Medical the as attending for use ed by the a detached t cate has been signed page 2 should be del Division or Vital Records, Completed by certificate Physician: director Be Certification: To

**Physician** 

Examiner

**Funeral** 

Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene.

ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at

Department c Important: If any injury or once.

**Physician** 

/Medical

Examiner

Baltimore, Maryland 21215-0036

/Medical

Director

Funeral

2

Completed

Be

ဥ

After this funeral or Attending death. 24 hours after death Funeral Director: filled in by Hospital To the the

Medical

31. Date filed (Month, Day, Year) State

2 Accident

3 Suicide

29a. Certifier

4 ☐ Homicide

(Check only

29b. Signature and title of certifier

29c. License number

1 🖸 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

D43083

1 Yes 2 No

October 26, 2006

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2006

3 1

6 ☐ Could not be determined

9707 Medical Center Drive, #300, Rockville, Maryland 20850 George A. Sotos, M.D.

32 Registrar's Signature 1815

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Registrar

State of Maryland / Department of Health and Mental Hygieney Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year Month 3:08 PM MILLER Physician OCTOBER 27 2006 ATTIE /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number, Examiner Baltimore Bon Secours Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months Days 1 M 2 F Yrs. No. Carolina Aug 5, 1926 80 223-34-4541 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State or 28a-f ahow the Medical Exercitiver thust be notified at 1 Yes 2 No **Baltimore** N/A Director Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21217 838 North Fulton Avenue - D Itams 23a by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: filed within 72 hours after 1 □ Never Married 2 □ Married 0 1 ☐ Yes 2 ☐ XNo Specify: Specify: Maryland 21215-0036 Black 3 □ Widowed 4 □ Divorced "natural" Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) al Hygiene. Own Home Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 12 Ith and Mental Hygie 27 Is marked other r traumatic event, III 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be Matilda Watson Rix Alston 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3655 Brenbrook Drive Randallstown, Maryland 21133 of Health a If Itam 27 le Kenneth Miller Son timore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 DBurjal 2 Cremation 3 Removal from State = 5 11/01/06 Baltimore, Maryland artment ortant: l' Injury o Arbutus Memorial Park 4 Donation 5 Other (Specify) 22. Name and Address of Facility 21. Signature of Firmeral Service Licen Depar Impor any In Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 21217 Approximate Interval Between Onset and Death 23a. Part. Enter the disease, or complications that caused the shock, or heart failure. List only one cause of ach line. bo not enter the mode of dying, such as cardiac or respiratory arrest, tmmediate Cause (Final disease or condition resulting in death) Wrest Pnysician /Medical Due to Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or Examine or Attending Physician: The law requires that the death certificate be executed use as the burial-transit and/ Due to (or as attending physicien P.O. Box 68760 Physician/Medical IF FEMALE 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy Year Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) ed by the a detached f 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, δ 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 100 1 ☐ Yes 2 ☐ No 1 ☐ Yes 26. Place of Death (Check only one) 25. Was case referred to medical Be Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 CEN Outpatient 1 Yes 2 No 3 DOA Certification: To After this 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 27. Manner of Death 1 Matural 5 Pending 1 ☐ Yes 2 ☐ No deeth. investigation filled in by the fo 2 ☐ Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide To the Hospital o within 24 hours of To the Funeral DI 1 🕱 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Agnature and title of certifier **RES000** 32. Registrar's Signature Date filed (Month, Day, Year) State Registrar

State of Maryland / Department of Health and Mental Hygiene 006 34528 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death O C + **Physician** Year Dennis Jesse McClain, Sr. 2006 11:20AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death ACNES HUSPITAL Baltimore Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth Month, Day, Year)

Feb 6, 1927 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign No. Carolina **Funeral** 1 DM 2 F Yrs. Director 212-34-7027 79 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location or then "neturel", or items 23a or 28e-f ehow the Medical Examiner must be notified at 10d. Inside City Limits **Baltimore** 1 ☐ Yes 2 ☐ No Directo Maryland N/A 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 21202 415 East Lafayette Avenue by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 ☐ Yes 2 ☐ XNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ Xo Specify: Black Specify 3 Widowed 4 Mivorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry le marked other then Garden State Tanning Elementary/Secondary (0-12) College (1-4or 5+) Supervisor 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame, 2 should be f and Mental I Roberta McClain Purcell McClain Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 146 East Franklin Street New Holland, Penn. 17557 of Health Felicia McClain Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If Ite
ony injury or ot 1 □ Burial 2 □ Kremation 3 □ Removal from State 10/28/06 Catonsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 21. Signature of Funeral Service License 22. Name and Address of Facility
Estep Brothers Funeral Service, P. A.
1300 Eutaw Place Baltimore, Md 21217 23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line leath. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Cerebro Vascu 7 Days /Medical Due to (or as a consequence of): Examiner Securitally list or ditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine The law requires that the death certificate be executed ed by the attending physicien and detached for use as the burial-transit resulting in death) Last Box 68760 Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown s been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, \$ 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed this certificate 2 2 No Division of Vital 1 Yes 2 No 1 🗌 Yes Hospital or Attending Physician: After this certification funeral director. 25. Was case referred to medical examiner? 26. Place of Death | Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3□ DOA 27. Manper of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Medical Certification: 28b. Time of 28d. Describe how injury occurred Japiter A hours efter dea.
- rel Director: After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide within 24 hours eff To the Funerel DI completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Ohack only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) PAYAM POJHAN MO 20283 october 212006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) STAGNES MOSPITAL, BALTIMORE, MD PAYAM POJHAN MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 1 2006 OCT 3 GOBAL! Registrar

DHMH 17 Rev 1/2001

Denni

cclain

State of Maryland / Department of Health and Mental Hygiens 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) OCTOBER **Physician** MARKMAN ଅଧିତ 2006 9:55 PM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner RAMPALLSTOWN BALTIMORE. CENTER HOSPITAL NORTHWEST If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 ☐ F **Director** 183-18-4633 07/04/1921 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
ant: If item 27 is marked other then "natural", or Items 23e or 28e-1 show 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits ral', or Itams 23a or 28a-f show Examiner rough be notified at MD BALTIMORE BALTIMORE 1 ☐ Yes 2 No Completed by Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2 CANDLEMAKER COURT #401 21208 <u>U.S.A.</u> 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify: WHITE Specify 3 ☐ Widowed 4 ☐ Divorced traumatic avant, It's Mudical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 OWNER RETAII 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ABRAHAM WAITZ 2 SADIE OSTROVESKY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, permit. Pages 1 and 2 s Department of Health ar Important: If item 27 Is any injury or othar trau once. PHILIP MARKMAN / HUSBAND 2 CANDLEMAKER COURT APT. #401 - BALTIMORE, MD 21208 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) BETH TFILOH CONG. 10/29/2009 WOODLAWN, MD 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licensee 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** AINOMUSMIA disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a sonsequence of): Examine and I-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Year Month Day 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 XNo 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by ARILINSONISM 1 ☐ Yes 2 EX No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 X No 2□ No 1 Tes 1 Yes To the Hospital or Attanding Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 No Cther: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient ို 2 ER/Outpatient 3 DOA After thi 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural
2 Accident 5 Pending 1 ☐ Yes 2 ☐ No death. investigation I Diractor: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide within 24 hours a To tha Funaral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical To the Fune completely f 29d. Date signed (Month, Day, Year) 29b. Signature PHYSICIAN D 42723 OCTOBER 26 an u NORTHWEST NORTHWEST HOSPITAL 5401 OLD COURT ROAD M CENTER 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AVYERAHALLI HARISH. m 32. Registrar's Signature 31. Date filed (Month, Day, Year) State OCT 3 1 2006 Registrar

State of Maryland / Department of Health and Mental Hygien [ 34530 1 - For State Registrat Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1 Decedent's Name (First Middle, Last) Year **Physician** Oct 2006 /Medical 4b. City, Town, or Location of Death Eacility Name (If not institution, give street and number) Examiner Nursing Home
7. Age (th yrs. last birthday) 91 Haven timore tonsuille If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, 6. Sex 5. Social Security Number **Funeral** Days Months Min 1⊠M 2□F 18-16-200 Yrs. Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland 10a. State 10d. Inside City Limits 10b. County 10c, City, Town or Location itema 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Be Completed by Funeral Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Avenue 4.3U 21238 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ō 1 ☐ Yes 2 ₺ No Specify: Black Specify 3 ☐ Widowed 4 ☐ Divorced "natural" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) al Hygiene. College (1-4or 5+) Yellow N Grade A 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) is marked o Naylor ARthur Helen ဂ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: if Item 27 is any injury or other trau once. Naylor 108 Pobert Dereny, Cotonsville .MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State National Men. tack: 10/30/2006 Laurel MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Vaugh C. Greene Funeral SVC 5151 Balto Nath Pike, Baltimore, MD 21. Signature of Funeral Service Licensee augher Trung 31730 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to infinitellate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Physician/Medical Examiner anding physicien and use as the burial-transit To the Hospital or Attending Physician: The law requires thet the death certificate be executed Due to (or as a consequence of): P.O. Box 68760, attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) signed by the a d be deteched for 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? MELLITERS 24a. Was an autopsy performed? 1 Yes 2 No 1 ☐ Yes 2/1 No Division of Vital funeral director, 25. Was case referred to medical examiner? 26. Place of Death | Check only one Hospital: 1 ☐ Inpatient Other: 4 vursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No ٩ 2 ER/Outpatient 3□ DOA this 28a. Date of Injury (Month, Day Year) Certification: 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1 Netural within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No death. 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type) Print) 7220 ASNEEM 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 2006 1 3 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1- For Amen d#5, perFH, CS3, 1/19/07 IT Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year LAKSHMI NAIR 7:15AM OCT 2006 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore 225 Wendover Rd. 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 91286. Sex 8. Date of Birth (Month, Day, Year) 1 / 1 0 / 1 9 2 1 9. Birthplace (State or Foreign Months Days Hours 1 ☐ M 2 🔀 F India 098-58-<del>9125</del> Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits XXes 2 □ No MD Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21218 225 Wendover Rd. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2€ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Specify: Asian Indian 1 ☐ Yes X No 3 ₩idowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Residence Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Vasudevan Pillai Narayani Amma 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 225 Wendover Rd. Baltimore, MD 21218 Radha Pathak - daughter 20b. Place of Disposition (Name of Evans Complete Company of other place Complete Cotober Company SRVS.—RUAR 29, 200 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Forest Hill, MD 4 ☐ Donation 5 ☐ Other (Specify) 2006 3 Newport Dr. MD Forest Hill MD 21. Signature of Purper I Service Licensee 22. Name and Address of Facility
Evans Funeral Chapel
And Cremation Services 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ardiovascular 4 hrs Due to (or as a consequence of): 3425 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ardiomyopathy (ischemic) 3 YRS 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctonic pregnancy Part 25. 27.

Physician /Medical **Examiner** burial-transit Division or Vital Records, P.O. Box 68760, by Physician/Medical

**Physician** 

/Medical

Examiner

Director

Be Completed by Funeral

r

Examine

Be Completed

Certification: To

Medical

298

29b. Signature and title of certifier

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and the funeral completely filled in by

cause of death?						
ly 4 □Unknown						
y findings available letion of cause of ☐ No						
th (Check only one)						
Route Number,						
ed. ne cause(s)						

29c. License number

D0058860

29d. Date signed (Month, Day, Year)

SUITESIS

BALTO, MD 21218

State Registrar

SHAWN DHILLON 3333 N. CALVERT MD 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

		-	For State Registrar	1104				d / Dep		t of H	ealth a	and M	lental Hy	giene Reg. No.	200	6	345	32
	Di i .		1. Decedent's Nam		_								2. Date of De Month	Day	20	Year	3. Time of	
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S!55pt	Funeral		5. Social Security N		6. Sex		ge (In yrs.	last birthday	) If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da	th v. Year)		9. Birthp	lace (State o	r Foreign
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	vision of Vital Records, P.O. Box 68760, 44 Attanding Physician: The law requires that the death certificate be executed rotest. After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit	d by Physician/Medi	Part II. Other sign	nificent conditi	ons contribu	iting to death	but not re	sulting in the	underlying	cause gr	ven in Part	t I.		tobacco (		ibute to t 3 ☐ Prol	he cause of cably 4 🔄	death? Unknown
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	Division of Vital Records, to Attanding Physician: The law requires that endeath.  Director: Affer this certificate has been signed in by the funeral director, page 2 should be endeath.	Certification:	3 Suicide 4 Homicide	6 ☐ Could		8e. Place of I building,	Injury - At I etc. <i>(Spec</i>	nome, farm, ify)	street, facto	ry, office			28f. Location City or To	(Street ar own, State	nd Numbe e)	er or Rur	al Route Nur	mber,
	Division of Vital Reconstitute to the Hospital or Attanding Physician: The law within 24 hours after death. To tha Funaral Director: After this certificate has completely filled in by the funeral director, page 2	Medical Ce	29a. Certifier (Check only one)	1 Certifyi 2 Medical	Examiner:	n: To the bea	of examin	owledge, de ation and/or	eath occurre	d at the t	ime, date a opinion, de	and place eath occu	, and due to the irred at the time	e cause(s , date an	) and ma d place, a	nner as s	stated. to the cause	(s)
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	Ď ⊶ S ⊶			N	Ju	X	1	4		D.	5 76	000	>	((	21.	50	106	)
	17	-	30. Name and ac	dress of person	who comple	eted cause o	f death (Ite	om 23a) (Tyr	De, Ptint)	N	عر	Bh	12 Pe	ark	(VI	UP.	ing a	21234
	Regis	State strar	31. Date filed (M	fonth Day Year	1 2000	32. Regi	strar's Sigr	nature	GORAL	and the same			/					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 34533 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year October Lakshmi Devi Ohri 26, 2006 0933A 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) 593<u>6 Muncaster Mill Road</u> Montgomery

9. Birthplace (State or Foreign Country) Derwood If Under 24 Hrs. 7. Age (In yrs. last birthday) If Under 1 Year Months Days 8. Date of Birth (Month, Day, Year) 5. Social Security Number Min Months Hours 1□M 2☑F Yrs 213-11-4337 100 12, 1906 India Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Maryland | Montgomery Derwood 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code 20855 5936 Muncaster Mill Road India 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. I □ Yes 2 If Yes, Give 1 □ Never Married 2 □ Married 2X No 1 ☐ Yes 2\times\text{No Specify: Specify: Asian Indian 3X Widowed 4 □ Divorced Year or Dates: Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 6 Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Kartar Chand Khosla Biant Kaur Khosla 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rishi P. Ohri/Son 5936 Muncaster Mill Road, Derwood, MD 20855 20b. Place of Disposition (Name of competery, crematory or other place)
Montgomery
Crematorium. Inc. 20a. Method of Disposition 20c. Location - City or Town, State 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue Bethesda, Maryland 20814-3501 October 28, 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Ligensee Wisconsin Avenue M00803 23a. Part 1. Enter the disease, or complications that daused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) Coronary edrs Isease am Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):

**Physician** /Medical Examiner

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death.

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Be Completed by

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Certification:

Medical

the Hospital or Attending Physician: The law requires that the death certificate be executed

Box 68760,

P.O.

Division of Vital Records,

permit. Page Department of Important: If eny Injury or onca.

**Physician** 

/Medical

10a. State

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**Examiner** 

**Funeral** 

Director

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r than "naturel", or items 23a or 28a-f sho the Modical Examiner plust by nutified at

filed within 72 hours after

Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. ent: If Item 27 is marked other than ury or other traumatic event, the Ma

Baltimore, Maryland 21215-0036

if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner

IF FEMALE:

9 Unknown

4☐Pregnant at time of death

23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal death 3 Ectopic pregnancy 5 Other (specify)

23d. Date of delivery Month Day

in the past 12 months?
1 Yes 2 No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Was decedent pregnant

23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

Year

25. Was case referred to medical examiner? 1 ☐ Yes 2 No

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Injury

26. Place of Death (Check only one) Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 28d. Describe how injury occurred

24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 No

27. Manner of Death 1 Natural 2 Accident 5 Pending investigation 6 Could not be determined 3 Suicide

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work?

28f. Location (Street and Number or Rural Route Number, City or Town, State)

24a Was an

1 Yes

autopsy performed? Yes 2 No

29a. Certifier (Check only one)

4 Homicide

1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

loms

29c. License number 151916

State Registrar

2. Registrar's Signature 31. Date filed (Month, Day, Year) OCT 3 1 2006

Name and address of person who completed cause of death (Item 23a) (T)

		-	For State Registrar	State of Maryland		rtment of H		Reg	enę2 () ( g. No.	06			
	Physicia		1. Decedent's Name (First, Middle, Last)			2. Date of Death Month OCTODER 2			28 2	28 2006 9:30 A M			
	/Medic Examin	al L	Edith C.	Oliver		Ab Cibi Tourn o		october	4c. County		9:30	АМ	
		er	4a. Fecility Name (If not institution, give street and number) 7901 Oak Point Court			4b. City, Town, or Location of Death Pasadena			Anne Arundel				
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)			If Under 1 Year   If Under 24 Hrs.   8. Date of E			inth 9. Birthplace (State or Foreign Country)				
	Director		212-09-3603	<sup>3 M 2</sup> ⋈ F 96	Yrs.	Months Days	Hours Will.	Aug. 03	1910	- Oodrii	" MD		
	put 🛦	-	Usuel Residence of Decedent  10a. State 10b. County	10c. City	Town or Lo	cation				10	d. Inside Cit	ty Limits	
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	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Heelih and Mental Hygiene.  If item 27 is marked other than "natural", or items 23a or 28a-f ehow or other traumatic event, the Madical Examirant must be notified at	rect	10e. Street and Number			10f. Zip Code			g. Citizen of V	What Count	ry?		
		Funeral Director	7901 Oak Point Court			21122				USA			
		ner	11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?	6. 13.	Was Decedent of H f Yes, specify Cuba	ecify Yes or No- Rican, etc.)		e - America ck, White, e				
36		by Fi	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	es, Give		1 ☐ Yes 2 ☐ No Specify:			. Wh	ite		
8		tedt	15. Decedent's Education 16a. Dece			dent's Usual Occupation 1 kind of work done during most of working			6b. Kind of Bu	b. Kind of Business/Industry			
215		Completed	Flementary/Secondary (0-12) College (1-4or 5+)			DO NOT use retired)							
7		To Be Con	8		1	Kitchen A	18. Mother's Name	/First Middle M	Hosp				
and			17. Father's Name (First, Middle, Last) Daniel Quigl	ev			Addie	Newt		,0)			
7	should be nd Mental marked c		19a. Informant's Name/Relationship (7	-	19b. Mailir	ng Address (Street	and Number or Rura	al Route Number,	City or Town,	State, Zip	Code)		
Baltimore, Maryland 21215-0036	and 2 seelth ar n 27 is er trau		Mary Ellen Rippe	toe (daughter)	790	01 Oak Po	int Court	Pasade	na. MD	2112	2		
Je,	as 1 a of Hee litem		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	Bomoval from State	metery, crei	sition (Name of natory or other pla	ce) Nov	01	0c. Location -	1			
Ĕ	Pag ment tent: I		4 Donation 5 Dother (Specify	New		edral Cem	20		altimo	re, M	arylar	ıd	
Bail	permit. Pages 1 and Department of Heelt Importent: If item 2' any njury or other?		21. Signature of Funeral Surviva Lights	500		Name and Address 3111 Moun	ess of Facility Itain Road	Stalling , Pasade	s Funer na. MD	ral H 2112	ome, F 2	·.A.	
			23a. Part 1. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  Approximate										
	Pnysician /Medical Examiner	4	Immediate Cause (Final disease or condition Sensis due & C. D. f. cit anterceoffs 12 days										
			resulting in death)	Due to for as a consequ	ience of):	1	00	Ant 1	bucking		3 44	.46	
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9 X	eath certific ettending p I for use as I	To Be Completed by Physician/Med	IF FEMALE:	23c. If yes, outcome of pregna						23d. Date of delivery			
Box.	es thet the d gned by the be deteched		23b. Was decedent pregnant 1 Live birth 2 Fetal death 3			□Ectopic pregnancy □ Other (specify)			Mo	Month Day Year			
P.0			9 Unknown		an- Did								
			X 6 7 6 6						acco use cont s 2 ☑ No	use contribute to the cause of death?			
oro	w requir been si should		Konde 7	acleure , mellifis		· Cata	11. 1		<u> </u>				
Vital Records,	The taw ete hes t pege 2 s		1 /abeli	, welly s		CLAVA MA	ieg/	24a. Was an autopsy perform	ed?/	prior to con death?	npletion of c	ause of	
E	ysicien: is certifice director, j									No 1 Yes 2 No			
Ž			examiner? 1 ☐ Yes 2 ☐ No	hor									
Division of	ding Ph h. After th funeral		27. Manner of Death  1. Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Wo		28d. Describe ho	w injury occur	red			
	To the Hospital or Attending within 24 hours efter death.  To the Funeral Director: After completely filled in by the fune	catio	2 Accident investigation 3 Suicide 6 Could not be	M 1 Yes 2 No				28f. Location (Street and Number or Rural Route Number,					
Σ		Certification:	4 Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				City or Town, State)					
_		Medical C											
	To the within To the comple	Me	29b. Signature and title of certifier	0	-		se number	i i	d. Date signe				
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  & SAVIA SCHUARTZ 300 Hogy Hall S, G3, Wd 21042										
	Ì		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)										
	1		31. Date filed (Month, Day, Year)	14cuf1LT 2 32. Pagistrar's Signa	ture	egital	01,00	) and	104	12			
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** SHIRLEY CONSTANCE PERKINS October 2006 /Medical acility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A Sina Hospital

5. Social Security Number Baltimore 0 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 6. Sex Age (In yrs. last birthday) 69 Yrs. Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 X F Director 216-34-2525 12/07/1936 MARYLAND Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 X Yes 2 □ No Director MD N/ABALTIMORE CITY 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21207 4510 WENTWORTH AVENUE USA Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. X Never Married 2 ☐ Married 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 ☐ Yes 2X No Specify: BLACK Specify: δ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) RETAIL MANAGER AMES DEPT. STORE 12TH is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 should be for and Mental F FALSBORO PERKINS GEORGIA JACKSON 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 to Department of Health at Important: If Item 27 Is any Injury or other trau ANNE JORDAN / SISTER 4510 WENTWORTH AVE., BALTIMORE, MD 21207 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 11/03/06 WINDSOR MILL, KING MEM. PARK 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenses HOWELL FUNERAL HOME 21207 AVE, BALTIMORE, 4600 LIBERTY HEIGHTS or, or hear allure. List only one cause on each line. Immediate Gause (Final disease or condition resulting death) Physician wells /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine certificate be executed burial-transit and Due to (or as a consequence of) attending physician Physician/Medical as the IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Month Dav Year 4☐Pregnant at time of death 5 Other (specify) detached the 9□Unknown 9 Unknown þ signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Winknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☑ No 24a. Was an has autopsy performe this certificate Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 1 Impatient 2 2 ER/Outpatient 3 DOA 27. Manger of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After (Month, Day Year) 1 Natural 5 ☐ Pending investigation death. 2 Accident 1 ☐ Yes 2 ☐ No To the Hospital or Attenct within 24 hours after death To the Funeral Director: in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Confirming Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier address of person who completed cause of

Registrar DHMH 17 Rev 1/2001

State

30. Name and

31. Date filed (Month, Day, Year)

2006

Baltimore, Maryland 21215-0036

P.O. Box 68760,

Records,

or Vital

Division

Known as Shirty

death (item 23a) (Type, Print)

OGOA,

32, Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 For State Registra Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year 1:56 S. PARSONS 28 2006 LEWIS 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death SINAL BALTIMORE BALTIMORE HOSPITAL OF CITU If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 219.18.0318 1 ☐ M 2 K F MD Usuel Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10h. County 10a State 1 Yes 2 No NA BALTIMORE MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 16315 POST OFFICE BOX USA 21210 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify: Specify: BLACK 3 ☐ Widowed 4 ■ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)
3 YRS PROPERTY MANAGER FEDERAL 1214 GRADE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) NEWE HAILEY CARL PARSONS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5309 ST. GEORGE AVE., BALTO. MD HERBERT BROWN 21212 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State GARRISON FOREST 11.02.06 4 ☐ Donation 5 ☐ Other (Specify) OWINGS MILLS, MD 21. Sign ture of Funeral Service Licensee 22. Name and Address of Facility VAUGHN C. GREENE FUNERAL SERVICE 5151 BAUD. NATL PIKE, BAUD. MO 21229 2 aughn 23a. Part1. Enter disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SEPSIS Due to (or as a consequence of): 1/2 month MULTIPLE MYELOMA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Dua to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown ARTERY DISEASE 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performedy 1 ☐ Yes 2 ☑ No 2 No 1 Tyes 26. Place of Death (Check only one)

Physician /Medical Examiner

**Physician** 

/Medical

**Examiner** 

Director

Completed by Funeral

**Funeral** 

Director

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permit. Pages 1 and 2 a Department of Health ar Important: If Itam 27 is any injury or other trau

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Baltimore, Maryland

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Examine and K burial-transit physicien a Physician/Medical as nding I etten for u signed by the e Completed by should should certificate las l director Be this Director: After that in by the funeral Certification:

The law requires that the death certificate be executed

Box 68760.

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Records.

of Vital

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or Altending Physician:

23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No

27. Mannett of Death

1 Matural

2 Accident

4 Homicide

ASON

SURRO

Hospital: 1 Inpatient 28a. Date of Injury (Month, Day Year) 5 Pending investigation

2 ER/Outpatient 3 DOA 28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, elc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

6 Could not be

determined

29c. License number

29d. Date signed (Month, Day, Year)

Hu

KES 000 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

32 Registrar's Signature 2006

OF BALTIMORE SINAI HOSPITAL

within 24 hours after To the Funeral Dire To the Hospital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) October 29, 2006 **Physician** 8:25 рм Betty Jane Pistel /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Sykesville Carroll Fairhaven If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, ept 28, Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, **Funeral** Days Hours 1 □ M 2 ☑ F 1929 77 214-24-8309 \$ept Marvland Director Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 No 28a-f sh notified Funeral Director MD Carroll Sykesville 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number a or 7200 3rd Avenue 21784 USA ns 23a must b Apt M517 death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 'natural', or items dical Examiner me 11 Marital Status Pages 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No white Specify: Specify: þ 3 X Widowed 4 □ Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) and Mental Hygiene. Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Richard McCulloh Carrie George 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) t of Health a Debbie Bryant daughter 835 Templecliff Road; Pikesville, MD 21208 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Important; If it any injury or o once. 11/4/06 Parkville, MD Parkwood Cemetery 21. Signature of Fun ral a rvice License Towkond Funeral Home: Incoa ns that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, use on each line. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complication shock, or heart failure. List only one complete the complete shock is the complete shock of the complete shock in the complete shock is the complete shock in the complete sh Immediate Cause (Final Physician Smal 9/06 - 10/06 disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off Physician/Medical Examine To the Hospital or Attending Physlcian; The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 Ves 2□ No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of certificate has the rector, page 2 s autopsy 2 No 1☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 1 Yes 2 No 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 ☐ Pending investigation 1 Yes 2 No 2 ☐ Accident within 24 hours after death.

To the Funeral Director: / 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 🖸 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

State Registrar

31. Date filed (Month, Day, Year,



who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

80. Name and address of person

29c. License number

29d. Date signed (Month, Day, Year)

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

Union

DOWN

Memorial

Hospital

M.D.

32. Hegistrar's Signature

2006

			1 - For State Registrar	State of M	Marylan		artment of		nd Mental Hy	giene	06	31.530
	Physici	an	1. Decedent's Name (First, Middle, Last Douglas C. Pase	")					2. Date of De Month Oct 27,	eath	Year	3. Time of Death
	/Medio		4a. Facility Name (If not institution, give		nr)		4b. City, Town,			4c. County		1:30 pm M
		(6)	4320 Berger Avenu  5. Social Security Number 6. Se		Age (In vrs.	ast birthday)	Baltim If Under 1 Year		4 Hrs. 8. Date of Bi	n/a		lace (State or Foreign
	Funeral Director		214-26-9151	M 2□F	75	Yrs.	Months Days	Hours	Min. (Month, Di Sept 1	ay, Year)		elace (State or Foreign etry) t Virginia
	/land		Usual Residence of Decedent  10a. State 10b. County		10c. City	, Town or Lo	cation				1	0d. Inside City Limits
	e Man	Director	MD n/a		В	altimo	re					M∑Yes 2 No
	with th		10e. Street and Number				10f. Zip Code			10g. Citizen of	What Cour	ntry?
	Jeath ma 23	Funeral	4320 Berger Avenu	12. Was Decede	nt Ever in U.	S. 13. V	21206 Was Decedent of		n? (Specify Yes or No Puerto Rican, etc.)	U.S.A.	ce - Americ	an Indian.
36	should be filed within 72 hours after death with the Maryland of Mental Hygiene. marked other than "natural", or itema 23a or 28e-f show imatic event, the Medical Exeminal must be rotified at	by Fur	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Force 1XXYes 2 [ If Yes, Give Year or Date:	□No		f Yes, specify Cut I□Yes 2 No		Puèrto Rican, etc.)	Bla Specif	ick, White, fy: Wh:	etc. ite
Maryland 21215-003	72 hou natura		15. Decedent's Edu (Specify only highest grad			16a. Deced	lent's Usual Occu	pation during most of	of working	16b. Kind of B	lusiness/Inc	dustry
12	within ene. then	Completed	Elementary/Secondary (0-12)	College (1-4c	ıτ 5+)	`life. L	DO NOT use retire	ed)	3	Easter	n Sta	inlocc
<u>0</u>	illed i Hygie other	Be Co	12th grade 17. Father's Name (First, Middle, Last)				Millwr		s Name (First, Middle	l		TIITESS
ylar	should be ind Mental is marked o	To B	Charles Pase					1	ıde M. How			
Mar	d 2 sh th and th sm 7 is m traum		19a Informant's Name/Relationship (T) Gloria Pase, wife						or Rural Route Numb , Baltimor		, State, Zip 21206	Code)
	ages 1 and 2 should b nt of Health and Ment: : If Item 27 is marked : or other traumatic e		20a. Method of Disposition			lace of Dispos	sition (Name of natory or other pla		Date	20c. Location		wn, State
altimore,	Pages Iment of tant: if it jury or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)		10	rison l	Forest	00	et 31, 200			
Ball	permit. Pag Department important: f eny injury o		21. Signature of Funeral Service Licens	500					Miller- D Baltimor		uneral 2120	l Home, Inc
À	Physician		23a. Parti) Enter the disease, or como shack, or heart failure. List only o Immediate Cause (Final disease or condition	lications that causine cause on each	ed the death line.	Do not ente	er the mode of dy	ng, such as ca	ardiac or respiratory a	Winest,	, _	Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or a	as a consequ	uence of):	e y gyro	0		CW per	0	Jess
	cuted id ansit	Examiner	Sequenfially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or a	is a consequ	ience of):						
8760,	icate be executed physician and s the burial-transit	dicai Exa	resulting in death) Last	Due to (or a	is a consequ	ience of):						
9	rtificat ng phy as th	Medic	IC SEMALE.	u								
O. Box	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcom 1 ☐ Live birth 4 ☐ Pregnant 9 ☐ U <i>n</i> known	2 Fetal at time of de	death 3 [	Ectopic pregnanc Other (specify)	у			ite of delive onth	ry Day Year
ď.	res that (igned b) be deta	by Ph	Part II. Other significant conditions co	ntributing to death	but not resu	Ilting in the un	nderlying cause gr	ven in Part I.	23e. Did 1	obacco use cont	tribute to th	e cause of death?
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Vital	ician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital: ,			100		f Death (Check only	one)		
	Phys ar this eral dir	): To	1 ☐ Yes 2 ☑ No '	1 ∐ Inpa 28a. Date of In	jury	ER/Outpatient 28b. Time of	28c. Inju		ing Home 5 Resi	dence 6 Oth		Hoggile
ion	Attending F death. ctor: After y the funera	ation	Natural 5 Pending investigation	(Month, L	Day Year)	Injury		rk? ]Yes 2∐No				
Division of	s after de al Directo ad in by t	Certification:	3 Suicide 6 Could not be determined	28e. Place of I building,	njury - At ho etc. <i>(Specify</i>	me, farm, stre	eet, factory, office		28f. Location ( City or To	Street and Numb wn, State)	er or Rural	Route Number,
	To the Hospital or Attending Physician: within 24 hours atter death.  To the Funeral Director: After this certific completely filled in by the funeral director.	edical	29a. Certifier (Check only one) Certifying Phy	sician: To the besiner: On the basis and manner	of examinat	wledge, death ion and/or i <i>n</i> v	occurred at the trestigation, in my	me, date and popinion, death	place, and due to the occurred at the time,	cause(s) and ma date and place,	and due to	ated. the cause(s)
	To t Withi To tl	M	29b. Signature and title of certifier	111	7		29c. Licens		,	29d. Date signe		
*	1		30. Name and address of person who co	ompleted cause of	death (Item	23a) (Type 5	Print)			00fol	30, -	1000
İ	077		Chu Shiang Ch	ch Hus	301	St. K	aul t	lace	#409	2/2	402	•
	Sta Registr		31. Date filed (Month, Day, Vear)  OCT 3 1 2006	32. Regis	trar's Signat	ure	3					

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Phy	sicia	_	I. Decedent's Name (First, Middle, Last)			PELTER	,	2. Date of Dea Month	Day Year	3. Time of Death
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Exa	amine				NTER	BALTI			N/A	
Fune	eral	5	. Social Security Number 6. Sex	7. Age (In yrs.		If Under 1 Year Months Days				rthplace (State or Foreign country)
Direc	tor	-	223 22 3313 A	M 2□F 81	Yrs.	World Day	Tiodis W	JAN. 16	5, 1925 VI	RGINIA
land	=	-	Usual Residence of Decedent 10a, State 10b, County	10c. C	ty, Town or Loc	cation				10d. Inside City Limits
Mary -f		10	MD. N	/A	BALTIMO	ORE				1 X Yes 2 □ No
th the	100	Director	Oe. Street and Number			10f. Zip Code			10g. Citizen of What C	ountry?
ath wi	MBILD		517 UMBRA STREET				21224		USA	
er de	100	Lanera		2. Was Decedent Ever in U Armed Forces?	J.S. 13. V	Vas Decedent of Yes, specify Cul	Hispanic Origin? ban, Mexican, Pu	(Specify Yes or No- erto Rican, etc.)	14. Race - Am Black, Wh	
D36		ý	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 TYes 2 □ No If Yes, Give Year or Dates: WW	II 1	☐Yes 2 No	Specify:		Specify: W	HITE
1215-0036 within 72 hours after death with the Maryland ene. then "naturel", or iteme 23s or 28s-f show		eg	15. Decedent's Educa	ation		ent's Usual Occu		- 4	16b. Kind of Business	s/Industry
2 ighin /	-	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	life. C	OO NOT use retir	•	vorking		
filed w			12TH 7. Father's Name (First, Middle, Last)	0	AL	JTO WORK	7	lama (Finat Atindala	GENERAL	MOTORS
Baltimore, Maryland 21215-0036 semit. Pages 1 end 2 should be filed within 72 hours at Department of Heelth and Mental Hygiene. mportent: If then 27 is marked other then "natural, or		ō	FLOYD PELTER					lame (First, Middle, NIECE	Maiden Sumame)	
aryland should be and Mental		0	19a. Informant's Name/Relationship (Type	e, Print)	19b. Mailin	g Address (Stree			or, City or Town, State,	Zip Code)
end 2 selth a n 27 is			WILLIAM T. PELTER,	JR./SON			RD., TIF		31794	
or He standard		2	0a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Re	1 .	Place of Dispos	sition (Name of natory or other pla	ace) !	Date	20c. Location - City o	r Town, State
Pages Freet of tents of the	d d		4 ☐ Donation 5 ☐ Other (Specify)	OA OA		CEMETER		/1/2006	BALTIMORE	, MARYLAND
Baltimore, Maryland 21215-0036 permit. Pages 1 end 2 should be filed within 72 hours after death with the Marylan Department of Heelth and Mentat Hygiene. Importent: if item 27 is marked other then "naturel; or iteme 28s or 28s-f show	g	1	21. Signature of Funeral Service Licens		22.	Name and Addr	ess of Facility	CHARLES S	ZEILER &	SON, INC.
		-	23a. Part1. Enter the disease, or corpolic	attons that caused the dea					ORE, MARYL	AND 21224 Approximate
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/Medi			disease or condition resulting in death)	A CLDO SIS  Due to (or as a consec	ruence of):					1 Hour
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at the deg		200	1 Yes 2 No	4□Pregnant at time of o	leath 5□	Other (specify) _			Month	Day Year
that if		E P	art II. Other significant conditions contr	ibuting to death but not res	sulting in the un	deriving cause g	ven in Part I.	23e. Did to	bacco use contribute t	o the cause of death?
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aw requires been si								24a. Was a	an 24b. Were a	utopsy findings available completion of cause of
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_ = 7		<u></u>	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury	28c. Inju Wo	nyat ork? ]Yes 2∐No	28d. Describe n	ow injury occurred	
JIVISION  or Attending after death. Director: After		2	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At h	ome, farm, stre			28f. Location (S	treet and Number or R	ural Route Number,
Lat or A			4 - Homicae	building, etc. (Specif	у)			City or Tow	n, State)	
Hoepital 24 hours a Funerel i	follow in	2	29a. Certifier (Check only one)	cian: To the best of my known; On the basis of examination	wledge, death	occurred at the testigation, in my	me, date and pla- opinion, death oc	ce, and due to the c curred at the time, o	ause(s) and manner a date and place, and du	s stated. e to the cause(s)
To the Hospital within 24 hours a To the Funerel Completely filled in			29b. Signature and title of certifier	and manner stated.		29c. Licen			29d. Date signed (Mon	
			LIEN HOUYEN, M	EDICAL DOCT	OR	RES-	-000		CTOBER 25	
15 1		3	Name and address of porson who com	ploted cause of death (Item	n 22a) /Tunn S	laine)				
17			Wayyer JOHNS HOPK	INS BAYVIEW ME	DICAL CE	NTER, 494	-U ERSTERN	EVENUE BAL	11 MONE, MAR	LAND 21224
Reg	State Jistrai		31. Date filed (Month, Day, Year)  OCT 3 1 2006	32. Registrar's Signa	IUI B					

			State of Maryland / Department o		Mental Hyg	giene nns	34541
_			1 - State Certificate C	of Death	F	Reg. No.	07071
	Physici	ian	1. Decedent's Name (First, Middle, Last)		2. Date of Dea Month	ith Day Year	3. Time of Death
	/Medi		Henry Padilla		Octob		9:35AM
	Examir	ner		m, or Location of Death		4c. County of Death	1
				osedale ear If Under 24 Hrs.	T	1001ti	more
	Funeral Director		5. Social Security Number 6. Sex 1 M 2 F 7. Age (In yrs. last birthday) If Under 1 Yes Months Da	ays Hours Min.	8. Date of Birth (Month, Day Oct 26	Year) 9. Birth	nplace (State or Foreign untry) dale MD
			Usual Residence of Decedent	7 57	OCL 26	2006 Rose	uale MD
	yland		10a. State 10b. County 10c. City, Town or Location				10d. tnside City Limits
	Mar a-f-	iç	MD Baltimore Rosedale			17	/ 1 ☐ Yes 2 X No
	in th	ire	10e. Street and Number 10f. Zip Cod	et	1	10g. Citizen of What Cou	untry?
	ath w	a	1 Catoctin Court, Apt. C 21237	7		U.S.A.	
	after dea or iteme	nue	Armed Forces? If Yes, specify C	of Hispanic Origin? (Sp Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White	
0036	within 72 hours after death with the Maryland ene. then "naturel", or Iteme 23a or 28a-f ehow the Mudical Examiner must be notified at	Completed by Funeral Director	1 X Never Married 2  Married	No Specify:E1 S	alvadori	ian Specify: H	ispanic
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土	be filed ital Hygi od other	Be	17. Father's Name (First, Middle, Last)	18. Mother's Nam-	e (First, Middle, i	Maiden Sumame)	
y	2 should be and Mental le marked o raumatic eve	2	Jose Padilla	Rugina			
A Jar	12 sh and lem		19a. Informant's Name/Relationship (Type, Print)  Jose Padilla  1 Catoctin C				p Code) 21237
e, 1	ges 1 and 2 should it of Health and Mer it Item 27 le marks or other traumatic		20a. Method of Disposition 20b. Place of Disposition (Name of		-		
De	nt of h		11☑ Burial 2 ☐ Cremation 3 ☐ Removal from State	place)		20c. Location - City or T	
Q₽	permit. Page Department Importent:		4 Donation 5 □Other (Specify) Holly Hill  21. Signal re of Fuheral Service Licensee 22. Name and Ad	10-30		Baltimore, 1	
Balt	permit. I Departm Importer any Inju		6/15 Pol	lair Road,	ler-Dipp	oel Funera ce, MD 212	1 Home, Inc
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of				Approximate
	Physician		shock, of heart failure. List only one cause on each line.  Immediate Cause (Finat disease or condition	Jasia			Interval Between Onset and Death
	/Medical		resulting in death)  a. Due to (or as a consequence of):	NESIU.			
	Examiner		Sequentially list conditions, b. Than ato phoric Dys	splasia			
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œ.	ne death the ette hed for	Physician/M	in the past 12 months?  1 Yes 2 No 4 Pregnant at time of death 5 Other (specify)	incy		Month	Day Year
P.O.	that the dead by the detached	hys	9 □Unknown 9□Unknown				
Ś	res the igned be de	þ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause	given in Part I.	1	pacco use contribute to	
orc	w requir been si should	Completed			1 Ye	es 2 No 3 Pro	bably 4 ØUnknown
Sec	e law hest	nple		· · · · · · · · · · · · · · · · · · ·	24a. Was an	n 24b. Were auto	opsy findings available impletion of cause of
a E	siclan: The certificete he rector, page				1 Yes 2	ned? death? 2 ☐ No 1 ☑ Yes	2□ No
<u> </u>	siclar certil	Be	25. Was case referred to medical examiner?  1   Yes   25   No	26. Place of Death		~	
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Division of Vital Records,	il or Attending Physiclan: The law requires thet the death certif after death. Director: After this certificete hes been signed by the ettending d in by the funeral director, page 2 should be detached for use a	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify)	ce	28f. Location (Str City or Town	reet and Number or Run	al Route Number,
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	To the Hospital within 24 hours a To the Funeral completely filled	Medicai	29a. Certifier  (Check only one)  1 ☑ Certifying Physician: To the best of my knowledge, death occurred at the  2 ☐ Medical Examiner: On the basis of examination and/or investigation, in m  and manner stated.	time, date and place, a sy opinion, death occurr	and due to the ca ed at the time, da	ause(s) and manner as s ate and place, and due to	tated. the cause(s)
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			h he have le	= S & & & &	1	0/27/020	
	0		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	7774		11-	
	Y .		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	1 Square D	rive, !	baltimore	MD. 21237
	Sta Registra		31. Date filed (Month, Day, Year)  OCT 3 1 2006				

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.
AMEND TIEM 5 Per H, C861, 11/21/06, WS
State of Maryland / Department of Health and Mental Hygiene 34542 Certificate of Death Reg. No. 3. Time of Death A 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Helen Marie Rogers 45 27 2006 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death HARFORE BELAIR HEALTHAND REHABILITATION CENTER BELAIR If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Feb. 13, 1917 5. Social Security N7419 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 □ M 2 □ √F Months Days Hours Mary Land 89 212-01-<del>7418</del> Yrs Feb. Usual Residence of Decedent 10h County 10c. City, Town or Location 10d. Inside City Limits Harford Abingdon 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21009 U.S.A. 3504 Back Pointe Court, No. 10 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ★ Married 1 ☐ Yes 2 ₹ No If Yes, Give Year or Dates: Specify: White 1 ☐ Yes 2 XNo 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) own home 12 years homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) William Schutte Anna King 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12009 Caspian Road, Kingsville, MD 21087 William C. Rogers, Jr./son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Dulaney Valley Mem. Gdns 10/30/06 Timonium, MD 4 □Donation 5 x Other (Specify) entombment 21. Signature of Funda Profice Lice 22. Name and Address of Facility
Schimunek Funeral Home of Bel Air, Inc. 610 W. MacPhail Road, Bel Air, Md. Park. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, spock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Metastatic disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Day 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 1 ☐ Yes 20X No 25. Was case referred to medical examiner? 26. Place of Death Check only one Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 45 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ₺No 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending Injury investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Division of Vital Records, P.O. Box 68760,

The law requires that the death certificate be executed

State Registrar

**Physician** 

Examiner

**Funeral** 

Director

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Itame 23a

death

permit. Pages 1 and 2 should be filed within 72 hours after deat Department of Health and Mental Hygiene. Important: If Item 27 is marked other the any injury or other traumer.

**Physician** 

Examiner

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29a. Certifier

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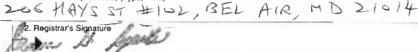
31. Date filed (Month, Day, Year) 3 1 2006

29b. Signature and title of certifier

elzand

KHOSLA

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

D56545

29d. Date signed (Month. Day, Year)

27/06

			1 - State Registrar	State of Mary		artment of H <i>tificate of L</i>		d Mental H	ygienę Reg. Né	71116	34543
	Dhyoisi		Decedent's Name (First, Middle, Last)	. D1	1_		<del></del>	2. Date of D Month			
	Physici: /Medic	al	Catherine Ella		Te	45 Cit. T.	1 ti4 S	October	28,	2006	3:30 P M
	Examin	er	4a. Facility Name (If not institution, give str 3710 Coronado Road			4b. City, Town, or Baltimo		eath		County of De	
	Funeral		5. Social Security Number 6. Sex	7. Age (In	yrs. last birthday)	If Under 1 Year Months Days	If Under 24	Hrs. 8. Date of B	irth		irthplace (State or Foreign Country)
	Director		214-24-3131	M 2 XF 78	8 Yrs.	Months Days		November			Maryland
	land		Usual Residence of Decedent  10a. State 10b. County	10	c. City, Town or Lo	cation		ara cosmi			10d. Inside City Limits
	Mary Ff sh	tor	Maryland Baltimore	<b>a</b>	Baltimo	re					1 □Yes ZANO
	or 28s	Directo	10e. Street and Number			10f. Zip Code			10g. Citi	zen of What	Country?
	ath wi	ral	3710 Coronado Road			2120					s of America
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural; or Iteme 23a or 28a-f show eny injury or other traumatic event, the Medical Examinar must be notified at once.	by Funeral	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☐ Widowed 4 ☑ Divorced	<ol> <li>Was Decedent Ever Armed Forces?</li> <li>1 ☐ Yes</li></ol>		Was Decedent of Hi f Yes, specify Cuba I □ Yes 2 🙀 No	ispanic Origin n, Mexican, P Specify:	? (Specify Yes or N uerto Rican, etc.)	10-	14. Race - Ar Black, Wi Specify: <b>T</b>	
21215-0036	thin 72 ho ie. ien "netur	Completed by	15. Decedent's Educa (Specify only highest grade Elementary/Secondary (0-12)	ation completed) College (1-4or 5+)	(Give	dent's Usual Occupa kind of work done o DO NOT use retired,	furing most of	working	16b. Ki	nd of Busines	s/Industry
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Maryland	d be find H	Be	17. Father's Name (First, Middle, Last)  William David By	ruchov			18. Mothers Catheri	Name (First, Middle  Lne Chro			
2	should nd Me mark mark	C	19a. Informant's Name/Relationship (Type	-	19b. Mailir	ig Address (Street a					, Zip Code)
	alth al		Sharon L. Winfield	1 (Daugh		Coronado					
Baltimore,	Pages 1 a lent of Hei nt: If item ry or othe		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Rei 4 ☐ Donation 5 ☐ Other (Specify)	moval from State	Ob. Place of Dispo cemetery, cren Woodlawn	natory or other place		Date L/01/06			or Town, State21207  Maryland
Balti	permit. Departmit. Imports eny inju		21. Signature of Funeral Service Licensee		22	. Name and Addres	s of Facility	Loring By	ers F	uneral	Directors, In
			23a. Part1. Enter the disease, or complications, or heart failure. List only one Immediate Cause (Final	ations that caused the		er the mode of dying	g, such as car	diac or respiratory	arrest,	<del>_</del>	Approximate Interval Between Onset and Death
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P.O. Box	The law requires that the death certificate has been signed by the attending plage 2 should be detached for use as t	Physician/M	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 Unknown	c. If yes, outcome of pi 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			1	23d. Date ol d Month	elivery Day Year
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Division of Vital Records,	or Attending Physician: The law require death. Director: Atter this certificate has been sign by the funeral director, page 2 should t	Completed						per	s an opsy formed?	death	autopsy findings available o completion of cause of
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Visi	or Attending Physician: after death. Director: Atter this certifical in by the funeral director.	Certification;	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - building, etc. (S	At home, farm, str			28l. Location	(Street and	d Number or	Rural Route Number,
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	To the Hospital or within 24 hours after To the Funeral Dirt completely filled in I	edical	(Check only one) 2 Medical Examine	and manner stated.	mination and/or inv	vestigation, in my op	pinion, death o	occurred at the time	, date and	place, and d	ue to the cause(s)
	With To t	Σ	29b. Signature and title of certifler	0.1 .		29c. License	number		29d. Dat	e signed (Mo	nth, Day, Year)
			- June 110	ne of the	4	4.	11843		/	0/30/	06
i			30. Name and a dress of person who com	pleted cause of death	(Item 23a) (Type,	Print)	her. A	1118 61	1160-	داند دانسار مر	MO 21042
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's	Signature -	A	ALL DI	CIVE ELI	- UI	C(/4	MU GIUTE
	Registr		OCT 3 1 201	16	M. A.	made 1					

State of Maryland / Department of Health and Mental Hygiene [] [] [ Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death OCTOBER 27 2006 CIIS A M **Physician** Tillie Sophia Rutkowski /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE WASHINGTON ANNEARUNDEL MEDICAL TE NTER GLEN BURNIE 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🖾 F Director 213-03-5940 89 12-17-1916 Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location ir than "natural", or items 23e or 28a-f show the Medical Examiner must be notified at 10d. Inside City Limits Funeral Director 1 ☐ Yes 2 No MD Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1565 Curtis Avenue 21060 Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. Int: If Item 27 is marked other than "natural", or Items 23 U.S.A 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give Maryland 21215-0036 1 Yes 2 No Specify: white Be Completed by Specify: 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Home maker Home Owner t of Health and Mental Hyg if Item 27 is marked other or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Martin Bochinski Louise Olszewska 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Glenn Rutkowski / son 15 Melissa Lane: Washin tonville, NY 10992 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ⊠ Burial 2 □ Cremation 3 □ Removal from State ō permit. Page Department of Important: If any injury or once. 4. Donation → Other (Specify) Holy Rosary 10-31-2006 Dundalk, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Singleton Funeral Home, PA 1 Second Ave SW; Glen Burnie, MD 21061 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betw Immediate Cause (Final LOBAR MEUMONIA **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner ATOZ Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 ☐ Ectopic pregnancy Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2/1 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner\* Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ 1 ☐ Yes 2 No Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours a To the Funeral [ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and tle of certifier 29c. License number 29d. Date signed (Month, Day, Year) ress of person who completed cause of death (Item 23a) (Type, Print 30 Name and ad Hospital WILE 31. Date filed (Month, Day, Year) 32. Registrar's Sign State 2006 Registrar 3

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ylar		To B	Bryan Platter				Mikae	ela Shafer		
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Baltimore,	Department Important; any injury once.	I	21. Signature of Funeral Service Lice	1500	22	Name and Ade	trace of Engilia.			
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_ _	hysician		shock, or heart failure. List only Immediate Cause (Final	one cause on each	line.		11 ^	(= ) - CT : ( o )		Interval Between Onset and Death
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JIVISION For Attending	after d Direct I in by	Certification:	4 Homicide determined	200. Flace 01 III	ijury - At home, farm, stre tc. <i>(Specify)</i>	et, factory, office	9	28f. Location (Street City or Town, Sta	and Number or R 1te)	ural Route Number,
- eticac	within 24 hours after death. To the Funeral Director: After this ce completely filled in by the funeral dire		29a. Certifier Certifying Ph	ysician: To the best	t of my knowledge, death	occurred at the	time, date and place	a, and due to the cause	(s) and manner a	s stated.
H e H	the Fu	Medical	one) 2   Medical Exam	and manner s	of examination and/or invi	estigation, in my	opinion, death occi	urred at the time, date a	and place, and due	e to the cause(s)
	T S		29b. Signature and title of certifier	1 Am	Mandida	ID DE	1se nu <i>m</i> ber - < (O)(()	29d. 0	Date signed (Mont	
	0		30. Name and address of person who	completed cause of	death (ftem 23a) (Type, F	Print)		. 00		26,2006
	+		Theodora Stavr	oudis, MI	) Johns H	4	Hospita	l 600 N. U	JolfeSt.	Balthmore, MD 212
	Stat Registra		31. Date filed (Month, Day, Year)	2006 32. Régist	rar's Signature	race	'			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
Amen diten#7, perFH, 0861, 11/2/06 TT
State of Maryland / Department of Health and Mental Hygierre () () () 34546 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** <sup>Day</sup> 27, LeRoy David Skillman October 2006 2:55 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 5471 Wingborne Court Columbia Howard If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year 1934)

Months Days Hours Min. July 15, 1943 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral**  Birthplace (State or Foreign Country)
\_\_\_\_\_\_ 10XM 2□ F Months 72 63 Director 064-28-2455 New York Usual Residence of Decedent 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heatth and Mental Hygiene. Important: If tem 27 is marked other then "natural; or items 23s or 28s-f show any injury or other traumatic event, tra Medical Exact in at must be notified at once. 10c. City. Town or Location 10d. Inside City Limits Directo 1 ☐ Yes 2 ☐ No Maryland Howard Columbia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5471 Wingborne Court 21045 Funerai USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠ Yes 2 □ No 195 If Yes, Give Year or Dates: 195 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1955 Black, White, etc. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💆 No ģ 1958 Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Landscape / Architect Transit Authority 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Frank Martin Skillman ပ Olive Stewart 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5471 Wingborne Court Columbia, Naryland 21045
Date 20c. Location City or Town, State Phyllis W. Skillman, Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc. 10/27/06 Baltimore, Maryland 21. Signature of Funeral Service Toensee
Thomas Gregor <sup>22</sup> Name and Address of Facility Cremation Society Of Maryland Inc. 299 Frederick Road Baltimore, Maryland 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betwe Immediate Cause (Final disease or condition resulting in death) nset and Death 217EIMERS DISEASE **Physician** /Medical Examiner S quentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) sicien and burial-transit or Attending Physician: The faw requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical the as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Feta! death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy igned by the ette be detached for in the past 12 months? 4☐ Pregnant at time of death Month Day Year 5 Other (specify) 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? No 3 Probably 4 □Unknown 24a Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy 1 ☐ Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) 1 Yes 2 No this 3 DOA 27. Manner of Death Certification: 28a. Date of Injury (Month, Day Year) After 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred s effer decay all process Afre 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital or within 24 hours of To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai (Check only one) 29b. Signature and tifle of certifie

State Registrar

31. Date filed (Month, Day Year)

DHMH 17 Rev 1/2001

ause of death (Item 23a) (Type, Print)

200 32. Registrar's Signature

2465 ROUTE

29d. Date signed (Month, Day, Year)

AT SUITE 10 BLENWOOD MO 21738

OCTOBER 27, 2006

State of Maryland / Department of Health and Mental Hygien 2006 34547 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month 12:45 AM Betty J. Smith Oct. /Medical 2006 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Keswick Multi Care Center Baltimore Baltimore City If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, YAUE. 11, 5. Social Security Number 6. Sex **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 M 2 K , 1935 South Carolina 217-34-9788 71 Yrs. Director Usual Residence of Decedent death with the Maryland 10a, State 10b. County 10c. City, Town or Location ir than "naturel", or itams 23a or 28a-f ahow The Madical Examiner must be notified at 10d. Inside City Limits Director XXYes 2 □ No Baltimore City Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3224 Westmont Ave. Completed by Funeral 21216 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married 1 Tes 2X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced Specify: black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiane. Elementary/Secondary (0-12) College (1-4or 5+) 10 Dietary Supervisor ulth and Mental Hygie 27 is marked other traumatic avent, II Nursing Home 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be finent of Health and Mental ! ဥ Elton Smith Eleanor Durrah 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health Item 27 Diane Smith - Daughter 3224 Westmont Ave. Baltimore, MD 21216 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages Depertment of Important: If it any injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Oct. 30, 06 Baltimore, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Cremation Society of Maryland, Inc. 299 Frederick Road Baltimore, MD 21228 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** vived mmono deticiency /Medical Due to for as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed burial-translt Due to (or as a consequence of): Box 68760, Physician/Medical use as the certificate hes been signed by the attending phy rector, page 2 should be detached for use as the IF FEMALE 23c. If yes, outcome of pregnancy 1□Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death Month Day 5 Other (specify) Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Completed 2 ☐No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an 1 Yes 2 No 25. Was case referred to medical 26. Place of Death Check only one Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 2 ER/Outpatient this 3□ DOA 27. Manner of Death After t 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending after death.

Diractor: Af
in by the fur investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 ☐ Could not be within 24 hours after d To the Funeral Direct completely filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the eause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 1)25205 LLUD October 30, 2006 who completed cause of donth (Item 23a) (Type, Print) Bolts. and 21200 M. Charles St. Binc 6701 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 3 1 2006

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 06 34548 Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 2006 /Medical 40. City, Town for Location of Death 4c. County of Death (If not institution, give street and (Omber) Examiner MOG If Under 24 Hrs 7. Age (In yrs. last birthday) 1 Year 9. Birthplace (State or Foreign Social Security Number If Under 8. Date of Birth **Funeral** Days Hours Min 1 1 M 2 □ F 249-42-049 926 South Yrs. Director June Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r than "naturel", or Iteme 23s or 28s-f show the Medical Examinar must be notified at 1 XYes 2 □ No Maryland

10e. Street and Number Directo more 10g. Citizen of What Country? 10f. Zip Code 23 21 Ave 201 Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 Mayes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Il Hygiene. other than Welder Department of Heelth and Mental Hyg Important: If Item 27 is marked other eny injury or other traumatic event, I <u>once.</u> 17. Father's Name (First, Middle, Last) Be unk ၉ 19a. Informant's Name/Relationship (Type, Print) (daughter) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pate 20c. Location - City or Town, State Fulton Av 2a.Wn 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1. Burial 2 ☐ Cremation 3 Removal from State 2006 Garrison Forest 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee oh L. Russ Funeral Home, P.A. W. North Ave. Balto. Md. 212 23a. Party Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) A SPIRATION PNEUMONIA **Physician** /Medical Due to (or as a consequence of): Examiner freus Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours alter death.

To the Funerel Director: After this certificate has been signed by the attending physician and completely lifed in by the Innoratul director, page 2 should be detached for use as the burial-transit Renal PAILUre Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Prost17110 Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 2 Fetal death 3 ☐Ectopic pregnancy Month Day 4☐Pregnant at time of death 5 Other (specify) 9☐ Unknown 9 Unknown Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2010 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an s certificate has t lirector, page 2 s autopsy performe 2 12 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Impatient 1 Yes 2 100 2 ER/Outpatient 3 DOA Medical Certification; To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Datural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year, 29c. License number

DHMH 17 Rev 1/2001

State

Registrar

Date filed (Month, Day, Year)

2006

31

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Jane Sullivan Salter 2006 8:05 AM October 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Baltimore Towson Gilchrist Center If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6, Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months 1 □ M 2 X F Mississippi 426-62-6556 78 October 11,1928 Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2 No Baltimore Maryland Baltimore 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 7203 Oxford Rd. 21212 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2)XX If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married 1 ☐ Yes 2 💢 No Specify: Specify: 3 Widowed 4 Divorced white 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) homemaker 4 own home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Juliette Stockett Barry Sullivan 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Julie Salter/daughter 7203 Oxford Rd. Baltimore, MD 21212 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Greenmount crematory Oct. 30,2006 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 22. Name and Address of Facility
Mitchell-Wiedefeld Funeral Home, Inc
Raltimore, MD 21212 21. Signature of Funeral Service Licenses 23a. Port. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, snock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CANCER with Metastases marths disease or condition resulting in death) Due to (or as a consequence of):

**Physician** /Medical Examiner

**Physician** 

/Medical

**Examiner** 

10a. State

Director

Funeral

Completed by

Be

P

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

the attending pl signed by the a d be detached f has e 2 page certificate |

The law requires that the death certificate be executed After this the Hospital or Attending within 24 hours aner common To the Funeral Director: Aft

Division or Vital Records, P.O. Box 68760,

Sequentially list conditions,	b			
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c			
	d.	e (i).		
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknowh	23c. If yes, outcome pf pregnancy 1 □Live birth 2 □ Fetal dea 4 □ Pregnant at time of death 9 □ Unknown	tth 3□Ectopic pregnancy 5□ Other (specify)	23d. Dat Moi	e of delivery nth Day Year
Part II. Other significant condition	s contributing to death but not resulting	in the underlying cause given in Part I.		ibute to the cause of death?  3 Probably Unknown
			autopsy performed?	Nere autopsy findings available prior to completion of cause of leath?  ☐ Yes 2☐ No
25. Was case referred to medical		26. Place of De	eath (Check only one)	
examiner? 1 ☐ Yes 💆 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/C	Outpatient 3 DOA Other: 4 Nursing	Home 5 ☐ Residence 6 10the	er (Specify) HOSPICE
27. Manner of Seath Natural 5 Pending 2 Accident investiga	(Month, Day Year)	. Time of Injury M 28c. Injury at Work?  M 1 Yes 2 No	28d. Describe how injury occurr	ed
3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin		farm, street, factory, office	28f. Location (Street and Number City or Town, State)	er or Rural Route Number,
29a. Certifier 1 Certifying (Check only one)	Physician: To the best of my knowled xaminer: On the basis of examination a and manner stated.	ge, death occurred at the time, date and plan and/or investigation, in my opinion, death occ	ce, and due to the cause(s) and ma curred at the time, date and place, a	nner as stated, and due to the cause(s)
29h Signature and title of certifier		29c. License number	29d Date signed	(Month Day Year)

125643

Charles Street/Balto

29d. Date signed (Month, Day, Year)

2006

Registrar DHMH 17 Rev 1/2001

State

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

lendallitravlurer

2006

Name and address of person who completed cause of death (Item 23a) (Type, Print)

WD

6601

Registrar's Signature

N.

			1- For Amend item#1, per D, &6	laryland , 11/22	d/Depa Cer	artment of H	ealth a Death	nd Mental	Hygien		34550
Ph	ysicia	an	Decedent's Name (First, Middle, Last)     Edward ]		erman, J	Jr.		2. Date Monti	n D	ay Year	3. Time of Death
//	Medic	al	EDGAR E K SAUERMAN	<del>JR</del>		4b. City, Town, or	Location of	Octo		0, 2006	7:05A M
Ex	amino	er	4a. Facility Name (If not institution, give street and number The Wesley	")		Baltimor		Deam	"	N//	
Fun	eral		5. Social Security Number 6. Sex 7. /	Age (In yrs. Ia	ast birthday)	If Under 1 Year Months Days	If Under 2		of Birth h, Day, Yea	9. Bir	rthplace (State or Foreign country)
Dire	ctor		212-18-9812 ¹ℜX ²□F	87	Yrs.	Morning Sujo	110010	Novemb	er 15,	1919 Man	ryland
land	=		Usual Residence of Decedent           10a. State         10b. County	10c. City	, Town or Lo	cation			_		10d. Inside City Limits
Man) 9-fsh	ped	to	Maryland N/A	Ba	ltimor	e					1, Yes 2 □ No
ith the	28.00	Dire	10e. Street and Number			10f. Zip Code			10g. C	itizen of What C	ountry?
eath w	Time	by Funeral Director	2211 West Rogers Avenue  11. Marital Status  12. Was Deceder	at Ever in II 9	2 12 1	2120 Was Decedent of Hi		in? (Specify Ver	or No-	USA 14. Race - Am	erican Indian
fter de ritem	Dec	Fun	1 Never Married 2 Married 1 Yes 20	s? SNo	1	f Yes, specify Cuba	n, Mexican,	Puerto Rican, etc	i.)	Black, Whi	
1215-0036 within 72 hours after death with the Maryland ene then "natural", or Items 23e or 28e-f show	Eng	d b	XX Widowed 4 □ Divorced If Yes, Give Year or Dates			1□Yes XX No	Specify:			Specify:	White
21215-0036 3d within 72 hours af giene. er then "natural", or	edica	Completed	15. Decedent's Education (Specify only highest grade completed)		(Give	lent's Usual Occupa kind of work done d DO NOT use retired,	luring most	of working	16b.	Kind of Business	s/Industry
vathir iene ithen	N S	omo	Elementary/Secondary (0-12) College (1-4o	r 5+)		gineer	,		М	anufactu	uring
e filed al Hygir other	vent.	BeC	17. Father's Name (First, Middle, Last)					's Name (First, M	iddle, Maide		
arylan should be ind Mental	atic e	To E	Edward E K Sauerman Sr					ma Belle			
Maryland  nd 2 should be filt lith and Mental Hy 27 is marked oth	treum		19a. Informant's Name/Relationship (Type, Print)  Wm. Bruce Pitcher Ner	hew	1	g Address <i>(Street a</i> 1 Court R					
re, N s 1 and f Health item 27	other		20a. Method of Disposition	20b. Pl	ace of Dispo	sition (Name of natory or other place		Date		ocation - City or	
Pages Pages nent of l	iry or		1/ Burial 2 ☐ Cremation 3 ☐ Removal from State  '4 ☐ Donation 5 ☐ Other (Specify)			Cemetery		1/1/06	Ba	ltimore,	Maryland
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "natural", or Items 23e or 28e-1 show	any inju		21. Signature of Funeral Service Licensee	aki	2) 22	. Name and Addres	s of Facility	6500 Yor Mitchell	k Road -Wiedef	Baltimore eld Funer	, Maryland 21212 al Home Inc
			23a. Part 1. Enter the disease, or complications that caus shock, or heart failure. List only one cause on each	ed the death	. Do not ente	er the mode of dying	g, such as c				Approximate Interval Between
Pnysi	_		Immediate Cause (Final disease or condition	TE	CAK	PIAC	AR	RYTHN	1/A		Onset and Death  Acule
/Med Exam	_			as a consequ	12	2221	210	1015/			VIDAN C
		ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	N AR	ence of):	CIEIC	11/2	ENDE			761163
cuted br	ransit	Examiner	that initiated events	105CL	LEROTI	C CARD	10 VAS	SCULAR	Dise	ASE	YEARS
8760, ate be executed			resulting in death) Last Due to (or a	is a consequ	ence of):						•
587 icate t	s the t	dical	d								
Box 6 eath certific	use a:	n/Me	IF FEMALE: 23c. If yes, outcome 23c. If yes, outcom			Te				23d. Date of de	livery
of Vital Records, P.O. Box 68 Physicien: The law requires that the death certific This certificate has been signed by the attending p	be detached for use as	Physician/Med	in the past 12 months?  1 Yes 2 No 4 Pregnant	at time of de		Ectopic pregnancy Other (specify)			_	Month	Day Year
P.O nat the d by th	letach	Phy	9 ☐ Unknown  Part II. Other significent conditions contributing to death		Iting in the ur	adarhina causa aiva	on in Part I	230	Did tobacco	use contribute t	o the cause of death?
ds, uires t	eq p	اک	Tat it. Other signmoon contains contributing to double	Dut Hot 1636	iting in the tr	idenying cause give	ar iii r cart ii.		1 ☐ Yes 2		robably 4 Unknown
Vital Records, sicien: The law requires t certificate has been signe	should	Completed							: Whas an	24b. Were a	utopsy findings available
Re( The lav	oage 2	mo:							autopsy performed? 'es 2'X N	death?	completion of cause of
/ita cien: ertifica	octor, I	Bec	25. Was case referred to medical examiner?					of Death (Check of			
Of \ Physical	al dire	2	1 ☐ Yes 2 No Hospital: 1 ☐ Inpa 27. Manner of Death 28a. Date of In		R/Outpatien 28b. Time of		4 Nur	sing Home 5		6 □Other (Spe	ecify)
Vision Attending r death.	funer	tion	1 Natural 5 Pending (Month, L	Day Year)	Injury	28c, Injury Work M 1 □ Y	at ? ∕es 2 ∐ N		nos now my	ny occurred	
Division of or Attending after death. Director: Afte	by the	Certification;	3 Suicide 6 Could not be determined 28e. Place of I	njury - At hor etc. (Specify)		eet, factory, office	-		on (Street a		ural Route Number,
itel or rel Dir	ni bel		- Dullding,	etc. (Opecity)	, 			City o	, rown, ola	6)	
Division of Vital Re To the Hospitel or Attending Physicien: The I within 24 hours after death. To the Funerel Director: After this certificate ha	ately fil	Medical	29a. Certifier (Check only one)  1 Certifying Physicien: To the besing and manner	of examinati							
Fo the vithin?	somple	Me	29b. Signature and title of certifier	1 1		29c. License	number		29d. D.	ate signed (Moni	th, Dey, Year)
	-		* Kolunt E 120	lypor	MD.	0-	1942	25	101	30/20	06
h			30. Name and address of person who completed cause of	death (Item	23a) (Type,	Print)	0.0	we vii	E 0	NO	1157 7:00
	CA		ROBGRT E. KBY JR 31. Date filed (Month, Day, Year) 32. Regis	strar's Signati	ure	// W.	14006	KY MU	6-B	4410,1	VI U- 41207
Re	Stat gistra		OCT 3 1 2006	Weed of	y. A	made					

DHMH 17 Rev 1/2001

DHMH 17 Rev 1/2001

		1 - For State Registrar	State of M	/larylar		artmen rtificat			and M			06	34551
Physic /Medi		1. Decedent's Name (First, Middle, I Jerome	•	Simms						2. Date of De.	r 27, 2	20 <b>08</b>	3. Time of Death 2:00 a M
Examir		4a. Facifity Name (If not institution, g				Pa	arkvi				Ba	ty of Death	ore
Funeral Director		5. Social Security Number 218–18–0737  Usual Residence of Decedent	Sex 7. A		last birthday) <b>84</b> Yrs.	If Under Months	1 Year Days	If Under 2 Hours	Min.	8. Date of Birt Month, Da July 2,	<sup>y.</sup> 1922	9. Birthr Cour Mary	place (State or Foreign ntry) /Iand
Maryland to show fied at	tor	10a. State 10b. County  MD Balti	.more	10c. C	ity. Town or Lo	cation kvill	Le					1	10d. Inside City Limits 1 ☐ Yes 2 🕱 No
th with the 23s or 28s	ai Director	10e. Street and Number 8820 Walther Bl	.vd.			10f. Zip	Code 2123	34			10g. Citizen of	What Cour	ntry?
-0036 hours after death with the Maryland tural, or Iteme 23s or 28a-f show at Exerciser count be neitified at	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 □ Widowed 4 □ Divorced	12. Was Deceden Armed Forces 1 X Yes 2 If Yes, Give Year or Dates	:? ]N¶WW ]	тт	Was Deced f Yes, spec	ify Cubai	spanic Orig n, Mexican, Specify:	gin? (Spe , Puerto f	cify Yes or No- Rican, etc.)		ice - Americ ack, White,	
7215- within 72 ane. than "na	Completed	15. Decedent's (Specify only highest g	Education grade completed) College (1-4or	r 5+)	life.	dent's Usua kind of wor DO NOT us DStal	rk doné d e retired,	uring most	of workir	ng	16b. Kind of E		dustry Service
nd file	To Be Co	17. Father's Name (First, Middle, La:	s <sub>t)</sub>			SCAT	OTEI	18. Mother	r's Name Stell		Maiden Sumai		
		19a. Informant's Name/Relationship								Arm,	nr, City or Town		Code)
altimore, mit. Pages 1 a partment of Hes portant: if item y Injury or othe		20a. Method of Disposition 1 ⊠ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec	city)	"  St	Place of Dispo cemetery, crem . Stani	natory or ot	her place	)		ate 30/06	20c. Location Dundal		
baltimo		21. Signature of Funeral Service			1	050 Y	ork	Ŕď.,	Tows	son, MD	21204		me, Inc.
Physician /Medical Examiner		Part1. Enter the disease, or co shock, or heart failure. List oni Immediate Cause (Final disease or condition resulting in death)	mplications that cause y one cause on each a	)	sta	er the mode	_				SPUS E	>	Approximate Interval Between Onset and Death
cate be executed physician and the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or a.										
certificate be executed certificate be executed ding physician and use as the burial-transit	edical		d										
is, r.C. box of the feath certification of the detached for use as be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Feta	if death 3	Ectopic pre Other (spe						ate of delive onth	ory Day Year
The law requires that the death the hes been signed by the atter bage 2 should be detached for c	by	Part II. Other significant conditions	contributing to death	but not res	ulting in the ur	derlying ca	use give	n in Part I.		23e. Did to			e cause of death? ably 4 □Unknown
	Completed									24a. Was a autops perform	med?	prior to con death?	psy findings available inpletion of cause of 2 No
Physician: This certificate all director, pi	To Be	25. Was case referred to medical examiner?  1  Yes 2 No	Hospital: 1 ☐ Inpati	ient 2 🗆	ER/Outpatien	3 □ DO	Other			(Check only or	n <i>e)</i> ence 6 □Oth	ner (Specifi	/)
To the Hospital or Attending Physician: within 24 hours elfer death within 24 hours before death To the Funeral Director: After this certifical completely filled in by the funeral director,	Certification:	27. Manner of Death  1 Description 5 Pending 2 Accident investigation		ury ay Year)	28b. Time of Injury	M 28	lc. Injury Work? 1 ☐ Y		28		ow injury occur		/
pital or Att urs efter d ral Direct		3 ☐ Suicide 6 ☐ Could not determined	building, e	tc. (Specif	y) 					City or Town	n, State)		l Route Number,
hs Hosp in 24 hou he Fune pletely fi	Medical	29a. Certifier 1 ☐ Certifying P (Check only one) 2 ☐ Medical Exa	thysician: To the best iminer: On the basis of and manner si	of examina	wledge, death tion and/or inv	occurred a estigation,	t the time in my opi	e, date and nion, death	place, ar occurred	nd due to the cand at the time, d	ause(s) and ma ate and place,	anner as sta and due to	ated. the cause(s)
To t To t	Σ	29b. Signature and title of certifier					License		4		9d. Date signe		
54		30. Name and address of person who	completed cause of	death (Item	n 23a) (Type, f	Print)	) 5	86	46		Octobs	4 2	7, 2006
り <sup>つ</sup> Sta	10	Anna Aonico	0-5	0	Wa 1	the	Ę	Bou	الح ب	200	Porku	Tle V	41) 51534
Registr	-1.7	OCT \$1	47	o olgila	A A	waste !							

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) Year **Physician** 29, 2006 1:55PM Lester Melvin Seal, Sr. October /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Westminster Carroll County 704 Grand Valley Court If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 2-02-1921 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days **№** 2 🗆 F 85 226-12-4853 Director Virginia Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours atter death with the Maryland nent of Health and Mental Hygiene. Int: If Item 27 Is marked other than "natural", or Items 23e or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County if of Health and Mental Hygiene.
If Item 27 Is marked other than "natural", or Items 23e or 28a-f show or other traumatic event, Ite Madical Examilier must be natified at 1 Yes 2 No Funeral Director Carroll Co. Westminster MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 704 Grand Valley Court 21158 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 XIXes 2 □ No If Yes, Give Year or Dates: WWII Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: white þ ¥XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Landscaper Landscaping 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be James William Seal Linda 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21158 19a. Informant's Name/Relationship (Type, Print) 704 Grand Valley Court Westminster, MD Lester M. Seal, Jr. Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition P Burial 2 K Semation 3 □ Removal from State permit. Page Department of Important: If any injury or once. 11/2/2006 Catonsville, MD Metro Crematory 4 Donation 5 Cher (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Burgee-Henss-Seitz Funeral Home, 3631 Falls Road Baltimore, Maryland Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Disseminated Intravascalen Coaquiation disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine the attending physician and hed for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Nonknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performe 1 Yes 2 No Hospitel or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 XNo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 28a. Date of Injury (Month, Day Year) filled in by the funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after deat To the Funeral Director: 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 29a. Certifier 🖎 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. icai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 10/30/06 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Drive Ste #340 Owings Wills and Crossroads M.D. 23 32. Registrar's Signature State Registrar 2006

DHMH 17 Rev 1/2001

			1 = For State Registrar	State of Ma	aryland		rtment of H tificate of L			giene2 Reg. No.	006	34553
i	Physici: /Medic		1. Decedemes Name (First, Middle, La	M M		5	ANDI	ERS	2. Date of De Month	ath Day	2006	3. Time of Death 5:45 PM
<b>)</b>	Examin		4a. Fecility Name (If not institution, giv 111 Point Pleasa	nt Road			4b. City, Town, or Glen Bur	nie		Ann	unty of Death	nde1
	Funeral Director		217-34-4017	M 2□ F 7. Age	68 (In yrs. la	ast birthday) Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Bir (Month, Da Oct.3,	y, Year)	9. Birth Cou	place (State or Foreign intry) PA
	death with the Maryland me 23e or 28e-f ehow frount be collified at	tor	Usual Residence of Decedent  10a. State 10b. County  MD Anne Aru:	ndel		Town or Lo						10d. Inside City Limits 1 ☐ Yes 2√ No
	with the	i Direc	10e. Street and Number 111 Point Pleasa	nt Road			10f. Zip Code 21060			10g. Citizer	of What Cos	untry?
20	d within 72 hours after death with the Marylan jene. r than "naturel", or iteme 23a or 28a-1 ehow the Wudical Examinar must be politied at	by Funeral Director	11. Marital Status  1 □ Never Married 2 ☑ Married  3 □ Widowed 4 □ Divorced	12. Was Decedent Armed Forces?  1  Yes 2  Yes, Give A Year or Dates:			Was Decedent of Hi f Yes, specify Cuba	spanic Origin? (S n, Mexican, Puerl Specify:	pecify Yes or No to Rican, etc.)	- 14.	Race - Amer Black, White ecify: Wh	, etc.
1213-003	within 72 hours after ene. then "naturel", or ite he Wedical Examina	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)	ducation ade completed) College (1-4or 5	j+)	(Give	lent's Usual Occupa kind of work done o DO NOT use retired,	turing most of wor	rking		of Business/l	
ylang z	2 should be filed v and Mental Hygie 'is marked other t reumatic event, In	To Be Co	17. Father's Name (First, Middle, Last Lester Jack Sande			Carpe	псту	18. Mother's Nar	me (First, Middle,			LIOII
Mary	id 2 sho ith and A 27 is ma treuma		19a. Informant's Name/Relationship ( Mrs. JoAnne Sande				g Address (Street a					
more,	permit. Pages 1 and 2 should be filed Depertment of Health and Mental Hyg Important: If item 27 is marked othe eny injury or other treumatic event, ance.		20a. Method of Disposition  1 Burial 2 Cremation 3 4 Donation 5 Olher (Special	Removal from State		ace of Dispo	sition (Name of natory or other place ke Cremat	e) Nov	Date	20c. Locat	ion - City or 1	
Baltimol	permit. Depertmit mporta eny inju		21. Signature of Funeral Service Lice		1014		. Name and Address Second A	<i>D</i> .	ingleton V GLen B	Fune	al Ho	ne, P.A.
)	Physician /Medical Examiner		23a. Part1. Enter the disease, or comshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	plications that caused one cause on each line.  Due to (or as	tas	totic		g, such as cardia	c or respiratory a	rrest,		Approximate Interval Between Onset and Death MMM
grou,	ficate be executed physicien and s the burial-transit	al Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as								
. Box o	death certi e attending id for use a	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	23c. If yes, outcome  1 Live birth  4 Pregnant at	2 Fetal	death 3[	Ectopic pregnancy Other (specify)			230	. Date of deli	very Day Year
ds, r.o	requires that the leen signed by th hould be detache	۵	9 Unknown  Part II. Other significant conditions		ut not resu	ilting in the u	nderlying cause give	en in Part I.		obacco use		the cause of death?
Hecord	e la has	Completed							24a. Was auto perfo		24b. Were au prior to death? 1 ☐ Yes	topsy findings available ompletion of cause of
Vitai	ysician: Th is certificete director, pag	Be	25. Was case referred to medical examiner?	Hoenital:			Other		ath (Check only	one)		
Ö	ding Phys h. After this funeral di	tlon: To	1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	1 Inpatie 28a. Dale of Inju (Month, Da	iry	ER/Outpatien 28b. Time of Injury	28c. Injury Work	4   Iturshiy r	dome 5 Resi 28d. Describe			rify)
DIVISION		Certification:	3 Suicide 6 Could not be determined	e Zee Place of Ini	ury - Al ho c. (Specify	me, farm, str	eet, factory, office		28f. Location ( City or To	Street and N wn, State)	lumber or Ru	ral Route Number,
	he Hospital or n 24 hours efte he Funerel Dir pletely filled in I	edical	29a. Certifier 1 Certifying P (Check only one) 2 Medical Exa	hysician: To the best miner: On the basis o and manner st	f examinat	wledge, deatl ion and/or in	n occurred at the tim vestigation, in my op	ne, date and place pinion, death occi	e, and due to the urred at the time,	cause(s) an date and pla	d manner as ace, and due	stated. to the cause(s)
)	To the I within 2: To the I complet	×	29b. Signature and title of certifier	126	)	An	29c. License	2143	8	29d. Date s	d 3	1 2006
	\U Sta	10	30. Name and address of person who  31. Date filed (Month, Day, Year)	Jila (E)	eath (Item	in	Print) 447 Oc	FENSE	that	WAY	Ada	VAPOLIS MD
	318	HE.	0.CT 3 1 200	h Rea	20	and the same of th	AR T					1

Division or Vital Records, P.O. Box 68760, the Hospital or Attending Physician: within 2

> State Registrar

29b. Signature and little of certifie

31. Date filed (Month Day Year) 2006

Paul M. Thambi, M.D.

20

Consider?

29c. License number

D0061083

9707 Medical Center Drive, #300, Rockville, Maryland 20850

29d. Date signed (Month. Dav. Year)

OCT 27, 2006

and manner stated

lo mo

2. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

		1 - For State Registrar	State of Ma	aryland / De		nt of H	ealth a	nd Mental F		2006	34555
		Decedent's Name (First, Middle, Las	t)					2. Date of	Death		3. Time of Death
Physici /Medi		Pourang Ra	ahmatabadi	Sohrabi				Octobe	er 18,	2006	5:10 P M
Examir		4a. Facility Name (If not institution, give	street and number)		4b. City,	Town, or	Location of	Death	4c.	County of Deat	h
		11721 Beall Mount	ain Road		Pot	omac			Mo	ontgome	ry
Funeral Director		210-27-1020	9x 7. Ag ☑M 2☐F	e (In yrs. last birtho 29 Yr	Months	1 Year Days	If Under 24 Hours	4 Hrs. 8. Date of (Month, Nov •	Birth Day, Year) 3, 1976	9. Birti Co Ira	nplace (State or Foreign untry) 3 N
Maryland f ehow	tor	Usual Residence of Decedent  10a. State 10b. County Maryland Montgome:	-y	10c. City, Town o							10d. Inside City Limits 1 ☐ Yes 2 1 No
h with the 23a or 28a st be notil	al Direc	10e. Street and Number 11721 Beall Mount	ain Road		10f. Zip	Code 20854			-	izen of What Co	
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Important: if Nem 27 is marked other than "natural", or iteme 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be notified at once.	by Funeral Director	11. Marital Status  1. Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 Yes 251 If Yes, Give Year or Dates:		13. Was Deced If Yes, spen	city Cuba	spanic Origi n, Mexican, Specify:	n? (Specify Yes or Puerto Rican, etc.)	No-	14. Race - Ame Black, White Specify: Wh	
21215-0036 ad within 72 hours af giene. er than "natural", or in a Madical Exam.	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)	ucation de completed) College (1-4or 5	(6	ecedent's Usua Give kind of wo	ork done d se retired,	ation furing most o	of working		ind of Business/	industry
and 2	To Be Co	17. Father's Name (First, Middle, Last)  Ovrang Rahmataba	2		Stude	ent	18. Mother	s Name (First, Midde	dle, Maiden	ollege Sumame)	
Maryland nd 2 should be file lith and Mental Hy 27 Is marked oth	ř	19a. Informant's Name/Relationship (7 Ovrang Rahmatabad	ype, Print) i <sub>F</sub> Sohrabi Father					or Rural Route Nur	nber, City or		ip Code) and 20854
Baltimore, bermit. Pages 1 ar Depertment of Hea mportant: If Item any Injury or othe		20a. Method of Disposition  1  Burial 2 □ Cremation 3 □  4 □ Donation 5 □ Other (Specify		20b. Place of D MaryTan Memoria	cominary of the	me of offallo	1	tober 21, 2006	20c. Lo	el, Mar	
Balti permit. Depertm Importa any Inju		21. Signature of Funeral Service Licens	600 Les M000			d Addres Ile, Ile,			Pump Monte -2805	hrey Fu comery A	neral Home venue
Pnysician /Medical Examiner		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a Cいっ	a consequence of)	Joun	te of dying	g, such as ca	ardiac or respiratory	arrest,	D	Approximate Interval Between Onset and Death
8760, care to be executed thy sicien and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	a consequence of):							
vision of Vital Records, P.O. Box 68760, Attending Physician: The law requires that the death certificate be executed or death.  ector: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death	3 □Ectopic pr 5 □ Other (sp				2	23d. Date of delin	very Day Year
Cords, F w requires tha s been signed should be del		Part II. Other significant conditions co	ntributing to death be	ut not resulting in th	e underlying c	ause give	n in Part I.	m in	d tobacco us ☐Yes 2[		the cause of death?
II Records, The law requires t	Completed							24a. Wi au pe 1 🗆 Yes	topsy rformed?	24b. Were aut prior to co death?	opsy findings available ompletion of cause of 2 No
/ita	Be	25. Was case referred to medical examiner?						f Death  Check on		-	
of value of this of this of all dire	၉	1 142 5 140		nt 2 ER/Outpa		Othe	f: 4 Nurs	ing Home 5 Re			ify)
Division of Vital or Attending Physician: I after death. Director: After this certifical lin by the funeral director, p	Certification:	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Injui (Month, Day		of ry 2 M	8c. Injury Work 1 🗆 Y	at ? ′es 2.XNo		25/10	exed gu	in shot
Division of Vital Rec To the Hospitel or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Certifi	4 Homicide determined	building, etc	He	me			סלמטטמו	irn R1	מכלניםן, יי	
Div To the Hospitel or within 24 hours afte To the Funeral Div completely filled in I	Medical	(Check only 2 Medical Exami	sician: To the best of ner: On the basis of and manner sta	examination and/o	r investigation,	in my op	inion, death	place, and due to the occurred at the time	e, date and	place, and due	to the cause(s)
To To		29b. Signature and title of certifier	secho	mo DME	_ 0	License	458		3 c	signed (Month,	250 <b>(</b>
1		30. Name and address of person who co					11.001	011		100 00°	
\ 	to	Ira N. Brecher, M 31. Date filed (Month, Day, Year)				Lve,	#304	Silver Sp	ring,	MD 2090	02
Sta Registr		OCT 3 1 2006	132 Nogistia	Di Ag	esti						

	1	For State Registrar	State of Man	yland / I		ent of H ate of L			Reg. No.	006	34556
Physician	n	Decedent's Name (First, Middle, Last	" Freddie	C. S	pratley	,		2. Date of De Month	Day	06	3. Time of Death
/Medica Examine Funeral	r	4a. Facility Name (If not institution, give BALL, MUZL VAME dic 5. Social Security Number 6. Se	street and number) ALCLNT		4b.	City, Town, or BAL+, nder 1 Year	MURE If Under 24 Hrs	th		Ounty of Deat	holace (State or Foreig
Director	-	214-50-7148  Usual Residence of Decedent  10a. State 10b. County	<b>3</b> ¢M 2□ F	57	Yrs. Mor		Hours Min	8. Date of Bir (Month, Da Feb 2	2, 1949	Co	Maryland  10d. Inside City Limits
Ba-f eho	ctor	,	I/A	oc. oily, row	en or cocation		altimore				1 ☐ Yes 2 ☐ No
h with th	a Dire	10e. Street and Number 2664 Gatehouse Drive			10	. Zip Code	21207		10g. Citize	on of What Co U.S	
IIS S	by Fur	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Eve Armed Forces? 1 Xes 2 No If Yes, Give Year or Dates:	1969 1971		ecedent of Hi specify Cuba es 2 1000	spanic Origin? (S n, Mexican, Puer Specify:	Specify Yes or No rto Rican, etc.)		I. Race - Ame Black, White pecify:	
filed within 72 he Hygiene. Ither then "naturent, ILe Mudical	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12)	ucation de completed) College (1-4or 5+)		Decedent's (Give kind of life. DO No. )	if work done o OT use retired	luring most of wo	orking	16b. Kind	of Business/	Industry
should be filed and Mental Hygic is marked other umatic event, it	lo Be		l Cook						vinia S	pratley	
and 2 sho lealth and m 27 is m		19a. Informant's Name/Relationship (T)  Carolyn C. Spratley	rpe, Print)	198				ural Route Number timore, Mary			Zip Code)
Pages 1 a nent of Hei int: If item iry or othe		20a. Method of Disposition  1	Removal from State	cemete	of Disposition ery, crematory son Fores	or other place	s Cemetery	Date 10/31/06	20c. Loca	owings	Town, State Mills, Md.
pernit. Page Department of Important: if any injury or		21. Signature of Funeral Service Licens	M. Wals	Bel?	22. Nam	e and Addres Estep E 1300 E	rothers Fur	neral Service Bantmore, M	P. A.	7	
ysicie	icai Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Acute Due to (or as a c  b. SePS Due to (or as a c  C. Due to (or as a c  d.	onsequence	of):	ailu	re				12 hour
The law requires that the death certificate be existence be as the has been signed by the attending physicien page 2 should be detached for use as the burian commissed by Dhyselvian Materials	Pnysician/med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑No 9 □ Unknown	23c. If yes, outcome of 1□Live birth 2 [ 4□Pregnant at tim 9□ Unknown	Fetal death		nic pregnancy r <i>(specify)</i>			23	d. Date of deli Month	ivery Day Year
w requires that it been signed by should be detactioned by Dr.		Part II. Other significant conditions co END Stage	_	not resulting i		ng cause give	on in Part I.	23e. Did t			the cause of death?
certificate has been rector, page 2 should be Completed.	Completed by				70			1 Yes	osy rmed? 2 No	24b. Were au prior to death? 1  Yes	ntopsy findings available completion of cause of 2000 No
hysician: this certific al director.	0 26	25. Was case referred to medical examiner?  1 Yes 2 No	Hospital: 1 Inpatient	2   ER/O	utpatient 3[	DOA Othe	· ·	ath (Check only of Home 5 Resid	300	☐Other (Spec	cify)
ng P fler t nera		27. Manner of Death  1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28a. Place of Injury (Month, Day Yi 28e. Place of Injury building, etc. (	· At home, fa	Time of Injury M arm, street, fa		at ? ∕es 2 □ No	28d. Describe I	Street and I		ural Route Number,
	Medical Cer	23a Conflier 1 Contifying Phy (Check only 2 Medical Exami	raician: To the best of n	my knowledg	ya, daath seeu nd/or investig:	med at the timation, in my op	e, date and plac pinion, death occ			nd manner as lace, and due	stated.
To the To the Complet	Med	29b. Signature and title of certifier  29b. Signature and title of certifier  30. Name and address of person who certifier	i — /	u.							2006
State	e	Kiarash Zarbali 31. Date filed (Month Parr Year) - 2	Man Inc	Signature	ONG	Y ENE	Stree	+ BAL	4 mor	e Mo	2-1201

DHMH 17 Rev 1/2001

FREDDIE C. SPRATLEY

Please Type or Print in Black Indelible Ink., Ensure All Copies Are Legible.

AMEND TTEM#5, perFH, C861, 11/20/06, WS
State of Maryland 7 Department of Health and Mental Hygiene 34557 1 - For State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Month Year **Physician** 14:51 PM eannell 06 0 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner HOSPITAL BALTIMORE G00D CAMARITAN If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Feb., 8) 5. Social Security Num369
231-82-0869
Usual Residence of Decedent 9. Birthplace (State or Foreign Country). 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 👿 F Yrs. Director irainia 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ortant: If item 27 is marked other than "naturel", or items 23a or 28a-1 show injury or other treumatic event, in a Madical Examinar must be notified at 1 X Yes 2 □ No Funeral Director Varyland more 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4408 21206 roc 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 MNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status t Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: Black by 3 ☐ Widowed 4 ☑ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry other than " Elementary/Secondary (0-12) College (1-4or 5+) redera resources DOVERNMENT 0 iman 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Department of Health and Mental Important: If item 27 is marked o Moore irTlee (Son) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) alto. Md. 21206 Ave aylor phannon 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 Ki Cremation 3 ☐ Removal from State Nount Crematory 11/9/2006 Balto.
2. Name and Address of Polity
Joseph L. Russ Funeral Home P.A.
2222 W. North Ave. Balto. Md. 21216 19 12006 Green 4 ☐ Donation 5 ☐ Other (Specify) 21. Sign to re of Funeral Servi Licenseany. 23a. Part1 Enter the risease, or complications that wised the death. Do not enter the mode of dying, such as cardiac or respiratory arrest ships, or heart finiting. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) PEA AWest activil Physician Puscless efection /Medical Due to (or as a consequence of): Examiner Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner the burial-transit ARDIOMYOPATH Due to (or as a consequence of): as IF FEMALE: be detached for use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 Probably 4 DUnknown page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2 No 1 Yes 2 1No 1 Tyes the funeral director. 25. Was case referred to medical 26. Place of Death | Check only one examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☐ No 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 🖺 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely ZLJ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year)

Division of Vital Records, this or Attending hours after death. To the Hospitel of within 24 hours at To the Funeral D

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Pages 1 and

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State Registrar

SWIFE 31. Date filed (Month Pay. 31 32. 2006

30. Name and 35 ress of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

SAMA , GOOD Registrar's Signature

MD

KITAN

MOSPITAL, BALTIMORE MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Lillian Catherine Valeri October 28, 2006 2:00 pm /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 2500 Wendover Road Parkville Baltimore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Jan 30, 1917 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 214-03-4287 Maryland Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at an once. 10c. City, Town or Location 10a. State 10d. Inside City Limits MD Baltimore Parkville Director 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2500 Wendover Road 21234 U.S.A. by Funeral 11. Marital Status Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: White 3 XWidowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Baltimore County Elementary/Secondary (0-12) College (1-4or 5+) Transportation Public Schools 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George Hasenei Marie Beane ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David S. Valeri-son 3518 Ellen Dr., Westminster, MD 21157 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Hilltop Serv Corp 10/31/06 Towson. MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee William G. Dau 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Rd., Towson, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** A cute ranal 10 day /Medical Due to (or as a consequence of): **Examiner** Uroser sis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 10 days Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed gastro intestinal Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 □Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ Mo 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autonsy performed? Yes 2 100 Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) Certification: To 1 ☐ Yes 2 ☐ No 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation after death.

Director: / 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours after To the Funeral Di completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Mon-o Kidung, mo P31865 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N. 821 Baltinge 2/20/

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

OCT 31

Division or Vital Records, P.O. Box 68760

32. Registrar's Signature

EN PERSON

2006

Please Type or Print in Black Indelible Ink

eviii L. VVasiiii		1- For State Certificate of Death	Re	eg. No. 2006 3455
Physici Iedical Exam			2. Date of Dea Month October 2	
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location University Hospital Baltimore	on of Death	4c. County of Death N/A
Funeral Director		215-92-3215 1 N 2 F 28 Yrs. Months Days Hot	ure Min	th (MM/DD/YYYY) 9. Birthplace (State or Foreign Country) MARYLAND
any		Usual Residence of Decedent  10a State		10d Inside City Limits
* .	tor	MD N/A BALTIMORE CITY		1 X Yes 2 No
ith the Mary 23a or 28a notified at	Director			0g. Citizen of What Country?  USA
hours after death with the Maryland insturalt", or items 23a or 28a-f she Examiner must be notified at once	Funeral	11 Marital Status 1 X Never Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No		- 14. Race - American Indian, Black, White, etc.
ırs after ural", o	by	3 Widowed 4 Divorced In Yes, Give Year 1 Yes 2 X No special or Dates:		Specify: BLACK  16b. Kind of Business/Industry
C1 2 -	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) UNEMPLOYED		Too. Time of Education Industry
21215-0036 hould be filed within 7 in Martal Hygiene. is marked other than tite event, the Medica	Be	LARRY L. WASHINGTON	ner's Name (First, Middle, M CHARMAINE I	BRAXTON
MD 212 d 2 should be the and Menta n 27 is market umatic even	J.			Tiber, City or Town, State, Zip Code)  LTIMORE, MD 21216
re, lan Hea fiten		20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
	0.8	4 Donation 5 Other Specify: MT. ZION CEMETERY 21. Signatury of Funeral Service Licenses 22. Name and Address of Faci	ility	LANSDOWNE, MD
Balt permit Depart Impor		(Whyse 6) Pour 4600 LIBERT	HOWELL I	FUNERAL HOME 21207 AV, BALTIMORE, MD
Physician /Medical		234 Fart I. Enter the disease, or complications that caused the death Do not enter the mode of dying, such as fail re. List only one cause on each line.	s cardiac or respiratory arre	est, shock, or heart Approximate Interval Between Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death)  a Gunshot wounds (2 of left leg and pelvis Due to (or as a consequence of):		
	Jer	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):		
ţ	Examiner	C. C. Due to (or as a consequence of):		
xecuted n and l - transi				
760, icate be executed physician and the burial - transit	Medical			23d. Date of delivery
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death or the Toneral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial – transi	Physician/	23b Was decedent pregnant in the past 12 months?  1 Live birth 2 Fetal death 3 Ecto 4 Pregnant at time of death 5 Other (Specify)	pic pregnancy	Month Day Year
D.O. Bc that the des ned by the s			Part I. 23e Did to	bacco use contribute to the cause of death?
ords, P.O  w requires that t as been signed b:	ed by			2 No 3 Probably 4 Unknown
Division of Vital Records, tal or Attending Physician: The law requints after death all Director: After this certificate has been seled in by the funeral director, page 2 should be a by the funeral director, page 2 should be a seled in by the funeral director.	Completed	E	24a Was a autop: perfor	sy prior to completion of cause of med? death?
Vital Rec ysician: The l his certificate l director, page	a)	© 25. Was case referred to medical 26. Place of Deal	th (Check only one)	2 No 1 Yes 2 No
of Vitaing Physici After this c	To B	O 1 Yes 2 No 1005-101 Inpatient 2 Y ER/Outpatient 3 DOA 011-1-4		Residence 6 Other
on of rending Pheath	ation;	1 Natural 5 Pending Oct 27, 2006 1828 hrs 1 Yes 2	— Subject shot	
Divisior pital or Attent ours after death lerral Director: filled in by the	Certification;	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify) Street	or Town, St	Street and Number or Rural Route Number, City tate)
To the Hospital within 24 hours. To the Funeral completely filled			place, and due to the cause	
To the Hos within 24 h To the Fur	Medical	29 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death and manner stated  29b Signature and file of certifier  29c License number		and place, and due to the cause(s)  29d. Date signed (Month, Day, Year)
		O.C.M.E.		October 28, 2006
h		30. Name and add as of pason who completed cause of death (Item 23a)  Mary G. Ryple MD. Deputy Chief Medical Examiner 111 Penn Street, Baltin	more. MD 21201	
	tate	te 31. Date filed (Month, Day, Year) 32. Registrar's Signature		
Regis	trar	ar OCT SI ZUUD James Jo		

		State of Maryland / Department of Health and Mental Hygiene  Certificate of Death  Reg. No. 2 0 0 C 0 L C 0
		1 - State Registrar Certificate of Death Reg. No. 2 0 6 3 5 5 6 6 6 6 6 6 6 6 6 6 6 6 6 6 6 6
Physic /Medi		Lois Ann Welsh October 23, 2006 4pm M
Exami		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death  2832 Lakeview Avenue  Sykesville  Carroll
Funeral Director		2832 Lakeview Avenue Sykesville Carroll  5. Social Security Number 217-30-5724   Carroll Sykesville   Carroll Syk
ס		Usual Residence of Decedent
Marylan f show ied at	tor	$ \begin{array}{ c c c c c c c c c c c c c c c c c c c$
n with the I 3a or 28a- st be notif	Funeral Director	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?  2832 Lake View Avenue 21784 USA
and 21215-0036  be filed within 72 hours after death with the Maryland ntal Hygiene.  ad other than "natural", or items 23a or 28a-f show event, the Medical Ex-miner must be notified at	by Funer	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 Never Married 2 Married 3 Widowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispanic Origin? (Specify Yes or Nolif Yes, specify Cuban, Mexican, Puerto Rican, etc.)  14. Race - American Indian, Black, White, etc.  1 Yes 2 No Specify: White
Maryland 21215-0036 at 2 should be filed within 72 hours af the and Mental Hygiene. It is marked other than "natural" or traumatic event, the Medical Eximi	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  College (1-4or 5+)  College (1-4or 5+)  College (1-4or 5+)
nd 2121 e filed within al Hygiene. other than "	Con	registered nurse health care
land Id be file ental Hy ked oth ic event	To Be	17. Father's Name (First, Middle, Last)  Clyde Schwinger  18. Mother's Name (First, Middle, Maiden Surname)  Adele Eck
IOCE, Marylar ges 1 and 2 should be at of Health and Menta if item 27 is marked or other traumatic e	-	19a. Informant's Name/Relationship (Type. Print)  Mr. H. Stanley Welsh (spouse)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  2832 Lake View Ave., Sykesville, MD 21784
of Hear item?		20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)  20c. Location - City or Town, State
Limor Pages Timent of I		4 Donation 5 Other (Specify) New Oakland Cemetery 10-28-06   Sykesville, MD
Baltimo permit. Page Department of Important: If any Injury or once.	il.	21. Signature of Faheral Service Licensee  HAIGHT FUNERAL HOME & CHAPEL, PA (Box 195)  Sykesville, MD 21784 (410)-795-1400
Physician /Medical		23a. Part1. Enter the disease, or complications that daused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause obtain line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):  Approximate Interval Between Onset and Death > 2.44.6
Examiner	Examiner	Sequentially list conditions,
68760, C. ificate be executed a physician and as the burial-transit	dical Exa	that initiated events resulting in death) Last  C
rtifical	Medi	IF FEMALE:
I Records, P.O. Box 6 The law requires that the death certifit ate has been signed by the attending I age 2 should be detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?  1  Yes 2  To 9 Unknown  23c. If yes, outcome pf pregnancy  1  Live birth 2  Fetal death 4  Tennths?  4  Pregnant at time of death 5  Other (specify)  Month Day Year
rds, P.O. I quires that the de n signed by the a		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death?  1 Yes 2 No 3 Probably 4 Unknown
	Completed by	24a. Was an autopsy performed performed death?  24b. Were autopsy findings available prior to completion of cause of death?  1 □ Yes 2 □ No
r Vital Roysician: The its certificate hidirector, page	Be C	25. Was case referred to medical examiner?
or Vita Physician: rthis certifici	2	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Hesidence 6 Other (Specify)  27. Mann of Death 28a. Date of Injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred
on C ding P h.	tion:	27. Manny of Death  1
Division ospital or Attending hours after death. uneral Director: After ly filled in by the funeral your part of the funeral p	Certification:	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)
Hospita 24 hours Funeral etely filled	Medical Ce	29a. Certifier (Check only one)  29a. Certifier (Check only one)  Check only one)  (Check only one)  Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  Cortifier (Check only one)  And manner stated.
To the within To the comple	Med	29b. Signature and little of certifier  29c. License number  29d. Date signed (Month, Day, Year)
6		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  PATRICK TURNS  Suize 102 1000 Ciberty Rd Elesbury and 21784  31. Date filed (Month, Day, Year)  32. Registrar's Signature
S Regis	tate trar	31. Date filed (Month, Day, Year)  32. Registrar's Signature

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygien 2006

Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** 25, Oct. 2006 7:56a Leroy Albert Wade, III /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Easton Talbot 27635 Ashby Drive 8. Date of Birth (Month, Day, Year) Dec. 18, 1 If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) 7 Age (In vrs. last birthday) 5. Social Security Number **Funeral** 1**X**1M 2□ F 49 Yrs. MD 219-64-9358 1956 Director Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10c. City. Town or Location 10a. State 10h County Show r 28a-f show MD 1 ☐ Yes 2√ No Director Talbot Easton 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code or items 23a or 2 27635 Ashby Drive 21601 USA death 1 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 20 No If Yes, Give Year or Dates: 14. Race - American Indian, 11. Marital Status Black, White, etc. s filed within 72 hours after I Hygiene. other than "natural", or ite 1 Never Married 2 Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: the Medical Exerþ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Wade Services College (1-4or 5+) Elementary/Secondary (0-12) Commercial Co. Owner 10 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Item 27 is marked oth any linjury or other traumatic event 2008. Be Margaret Williams Leroy Albert Wade, Jr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 27635 Ashby Drive, Easton, MD 21601 Melissa Faye Wade/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Oct 31, 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Baltimore, MD Metro Crematory 4 ☐ Donation 5 ☐ Other (Specify) Rarranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy, Severna Park, MD 21146 ng of Puneral Service Licensee Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part1. Enter the disease, or complications that caused the death, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Cavcinouna Omos **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) igned by the ettending physicien and be detached for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 The law requires that the death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Year Month Day 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ۵ 2 No 3 ☐ Probebly 4 ☐ Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Wasan 1 ☐ Yes 20 No 1 ☐ Yes 2 ☐ No or Attending Physician: To the Hospital or Attending Physician: within 24 hours after death.

To the Funerel Director: After this certific completely filled in by the funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one) Other: 4 Nursing Home State Residence 6 Other (Specify)

Injury at 28d. Describe how injury occurred 1 Inpatient 1 ☐ Yes 2 No 2 ☐ EB/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 27. Manner of Death Injury 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bestgate Rd. Annapolis, u.a. selouicu, wo 900 32 Registrar's Signature 31. Date filed (Month, Day, Year) State 2006 Registrar

		•	For Stete Registrar	State of	Maryland	-	rtment of H		ental Hygie	2006	34562
ī			Decedent's Name (First, Middle	, Last)					2. Date of Death Month	Day Yeer	3. Time of Death
	Physicia /Medic		Alice L. Will	iams			Oct. 29		2:25 A M		
	Examin		4a. Facility Name (If not institution		er)		4b. City, Town, or	Location of Death		4c. County of De	ath
			Westminster N	ırsing Cent	er		Westmi			Carro	l1
	Funeral		5. Social Security Number	6. Sex 7.	Age (In yrs. la	* * * * * * * * * * * * * * * * * * * *	If Under 1 Year Months Days	tf Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y	'ear) (	irthplace (State or Foreign Country)
	Director		215-52-3382 Usual Residence of Decedent	13.11.231	81	Yrs.			Feb. 5,	1925 Vi	rginia
	land		10a. State 10b. County		10c. City,	, Town or Lo	cation				10d. Inside City Limits
	Marylan -f ehow	ρ	MD Carro	111	Was	stmins	tor				1 ☐ Yes 2 X No
	r 28a	Director	10e. Street and Number		WC	o chiarino	10f. Zip Code		100	. Citizen of What (	Country?
	death with the Maryland ms 23a or 28a-f ehow r must be notilled at	O is	1605 East Mayb	erry Road			21158			USA	
	deat ms	Funeral	11. Marital Status	12. Was Decede		S. 13. V		lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No-	14. Race - An Black, Wh	
0	or its	F	1 Never Married 2 Marr	ied 1 ☐ Yes 2			Yes 212 No	Specify:		Specify:	me, etc.
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0	filed Hygi Sther		17. Father's Name (First, Middle,	Last)	1.		marci	18. Mother's Nam	e (First, Middle, Ma	Home	
and	id be ental Ked o	To Be	Pryor Hendrick	s				Annie Ma	ρ		
3	shound M		19a. Informant's Name/Relations			19b. Mailin	g Address (Street		al Route Number, (	City or Town, State	, Zip Code)
Ž	alth a		Edna Dunston -	Daughter		1605	East May	berry Ro	ad Westmi	nster. M	0 21158
e G	permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryla Deperment of Health and Mental Hygiene. Depertment of Health and Mental Hygiene. In Important: If then 27 is marked other then "natural", or items 23a or 28a-f ehov eny injury or other treumstic event, the Modical Examinar must be notified at once.	1	20a. Method of Disposition 1  Burial 2XX cremation	2 Demouslifeen St	1 00	ace of Dispo	sition (Name of natory or other place		Date 20	c. Location - City	or Town, State
Ĕ	Page nent ant: if ary o		4 □ Donation 5 □ Other (S			ro Cr	ematory	Oct.	30, 06	Baltimore	e. Min
Бапппо	permit. Depertr Import eny inje		21. Signature Funeral Service	Licensee	. /	22 C	Name and Addre	ss of Facility	of Maryla Baltimor	nd Tno	,
	20559		MINI	"Iaani	acl	2	99 Freder	cick Road	Baltimor	e. MD 21	228
			23a. Park. Enter the disease, or shock, or heert failure. List	complications that cau	used the death. ch line.	. Do not ente	er the mode of dyin	ig, such as cardiac	or respiratory arres	t,	Interval Between
F	Physician		Immediate Cause (Final disease or condition	. (	cereb	NAL	Uncu	la to	cident		Onset and Death
	/Medical Examiner		resulting in death)	Due to (or	r as a consequ	ence of):					
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200	ificate g phy as the	edic		0.							
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	deatl	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐ Pregnar	th 2 Fetal nt at time of de		]Ectopic pregnancy ] Other (s <i>pecify</i> ) _	<i>'</i>		Month	Day Year
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Vital	sician: Th certificete rector, pag	Be	25. Was case referred to medica examiner?	Hospital:			Oth		th (Check only one)		
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DIVISION	deat deat ctor: y the	fica	3 ☐ Suicide 6 ☐ Could	not be 290 Ptage of	of Injury - At ho	me, farm, str	eet, factory, office		28f. Location (Stre	et and Number or	Rural Route Number.
2	after after Dire	Certification:	4 Homicide	building	g, etc. (Specify	)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		City or Town,		,
	e Hospital or Attending Physician: T 24 hours after death. Proverel Director. After this certificat e Funeral Director. Proveral director, po-	alC	29a. Certifier 1 Certifyir	ng Physicien: To the b	est of my know	wledge, death	occurred at the tir	me, date and place,	and due to the cau	ise(s) and manner	as stated.
	I 4 II 0	edical	(Check only 2 Medical one)	Examiner: On the bas and manne	sis of examinat	ion and/or in	vestigation, in my o	ppinion, death occur	red at the time, dat	e and place, and d	ue to the cause(s)
	To the within 2 To the complet	Ž	29b. Signature and title of certifie	r /			29c. Licens	e number	290	d. Date signed (Mo	1
	1						DO	05074	3	11/30	16
Ì	4		30. Name and address of person		-						
	1		Ernesto Mendo	za, M.D. 6	86-C Po	ole R	oad Westm	inster, 1	1D 21157		
	Sta Registi	ate rar	31. Date filed (Month, Day, Year)	Jan He	gistrar's Signar	We de la constant de	2421				
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	Physici /Medio		1. Decedent's Name (First, Middle, Last,	nite				2. Date of Death Month	Day	Year	3. Time of Death A
	Examir Funeral Director		4a. Facility Name (If not institution, give 925. N. Bro 5. Social Security Number 6. Sec 249 - 46 - 7152	padway	last birthday) _ Yrs.	4b. City, Town, or Locati Bail 1 If Under 1 Year If Un Months Days Hou	MO (G		4c. County of Year)	of Death	ace (State or Foreign fr) Carplina
	Maryland a-f ehow	tor	Usual Residence of Decedent  10a. State 10b. County		y, Town or Loc					10	od. Inside City Limits 1   Yes 2 □ No
	h with the 23a or 28a	al Direc	10e. Street and Number 925 N. Broad	way		10f. Zip Code 2.1 2.0 _	5	10	g. Citizen of W	hat Count	ry?
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 ie marked other than "natural", or Iteme 23e or 28e-f ehow any injury or other traumatic event, Ite Musical Examinar must be notified at ODCe.	by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	If	as Decedent of Hispanic Yes, specify Cuban, Mex ☐ Yes 2 No Spec	cican, Puerto	ocify Yes or No- Rican, etc.)		- America c, White, e	
21215-0036	d within 72 ho piene. r than "natur tre Mudical	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	cation (e completed) College (1-4or 5+)	(Give k	ent's Usual Occupation ind of work done during r O NOT use retired)	most of worki	ng 1	6b. Kind of Bus	iness/Indu	ustry
Maryland 2	nould be filed I Mental Hyg narked othe	To Be C	17. Father's Name (First, Middle, Last) Hilton De	witt		Io	la W	(First, Middle, M	S De	ewi	tt
-	1 and 2 sh Health and em 27 le n ther traun		19a. Informant's Name/Relationship (Ty  MS. Doretha  20a. Method of Disposition	ewis	19b. Mailing 5   4	Address (Street and Nu 1. Glover	St.	Balt	City or Town, S C. Md Oc. Location - C	213	205
Baltimore	il. Pages intment of intent: If It injury or o		1 Burial 2 Cremation 3 F 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licens	Removal from State	inity	entory or other place) Cemetery	11/1/3	2006 I	unde	ūΚ,	Md.
Ba	Deperment of the position of t		· Joseph	L. Russ	70 22	seph L. R.	h Ave	uneral Balt	o. Mdi	212	Approximate
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,8260,	cate be executed physician and the burial-transit	dicai Ex	resulting in death) Last	Due to (or as a consequent.	uence of):						
P.O. Box 6	death certiff e attending id for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 22 No 9 □ Unknown	23c. If yes, outcome of pregnal 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown	death 3 🗆	Ectopic pregnancy Other (specify)			23d. Date Mont	of delivery	y Day Year
	The law requires that the ate has been signed by th page 2 should be detache	þ	Part II. Other significant conditions cor	ntributing to death but not results	ulting in the und	derlying cause given in Pa	art I.		Did tobacco use contribute to the cause of death?		
Division of Vital Records,		Completed	COPD					24a. Was an autopsy perform	ed? de	or to compath?	sy findings available pletion of cause of
f Vita	hystcian: Th his certificate I director, pag	To Be	25. Was case referred to medical examiner?  1 Ves 2 No	Hospital: 1   Inpatient 2   1	ER/Outpatient	Other	lace of Death Nursing Hon	Check only one	ce 6 □Other	(Specify)	
sion c	Attending Physician: r death. ector: After this certifici by the funeral director,	Certification;	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work? M 1 □ Yes 2		8d. Describe how	injury occurre	d	
Divi	o the Hospital or Attent within 24 hours after death the Funeral Director: completely filled in by the		3 Suicide 6 Could not be determined	28e. Place of Injury - At ho building, etc. (Specify	()			8f. Location (Stre City or Town,	State)		
	To the Hospital or within 24 hours after to the Funeral Dir. completely filled in I	ledical	one)	sician: To the best of my knowner: On the basis of examinat and manner stated.	wledge, death of tion and/or inve	occurred at the time date stigation, in my opinion,	and place, a death occurre	and due to the cau ed at the time, dat	e and place, ar	ner as stat id due to t	he cause(s)
)	S AND PROPERTY.	Σ	29b. Signature and title of certifier	Kellert v	mD	29c. License numb			d. Date signed $10/2$		* '
0			30. Name and address of pers no co	m eted buse of death (Item  Fast B	23a) (Type, P	DOOG re Medica	1 Cent	er Ba	OD E. E.	ager	St D 21202
	Sta Registr		31. Date filed (Month, Day, Year)  OCT 3 1 20	32. megistrar's Signat	ture	who .					

06-08099

Please Type or Print in Black Indelible Ink Ernest Wynn State of Maryland / Department of Health and Mental Hygiene 1- For State 2006 34564 Certificate of Death Registrar Reg No Decedent's Name (First, Middle,Last) Physician/ 2. Date of Death **Medical Examiner** Month Day October 27, 2006 Ernest Wynn 2128 hrs 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Johns Hopkins Bayview Medical Center Baltimore 5. Social Security Number **Funeral** 6. Sex If Under 1 Year | If Under 24Hrs 8 Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign Director Months Hours 223**-**24-5855 1 X M 2 01/08/1924 VA Usual Residence of Decedent 10a State 10b County 10c. City. Town or Location 10d Inside City Limits 28a-f shov MD Baltimore Turner Station notified at once. X Yes 2 10e. Street and Number 10f. Zip Code 10g Citizen of What Country ö 210 Chestnut Street 21222 **23**n USA Funeral . Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or Noor items Examiner must be Armed Forces? 14. Race - American Indian, Black X Never Married If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 2 Married 2 Divorced If Yes, Give Year 1943-46 Widowed "natural" 5 1 Yes 2 X No specify Specify Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry during most of working life DO NOT use retired) Elementary/Secondary (0-12) Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 72 I Department of Health and Mental Hygiene College (1-4 or 5+) other tranmatic event, the Medical marked other than Compl Steel Worker Bethlehem Steel 17. Father's Name (First, Middle, Last) 18 Mother's Name (First, Middle, Maiden Surname) Be <u>Richard Wynn</u> <u>Irene Crawley</u> 19a Informant's Name/Relationship (Type, Print ) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) If item 27 Willie Wynn/Sister-in-law 129 Carver Road Baltimore, Maryland 21222 20a. Method of Disposition 20b Place of Disposition (Name of cemetery 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State crematory or other place) Important: Donation 5 Other Specify Forest Cem. <u>11-</u>3-06 Owings Mills, 21 Signature of Funeral Service Licensee 22 Name and Address of Facility James A. Morton & Sons F.H., Inc. 1701-31 Laurens St. Baltimore, MD Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Approximate Interval failure. List only one cause on each line. /Medical Between Onset and Immediate Cause (Final disease a Multiple Injuries Examiner Death or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause Enter Underlying Cause Examine Due to (or as a consequence of): Due to (or as a consequence of) events resulting in death) Last and Physician/Medical g physician a UNPENDED AMENDED O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 23d Date of delivery past 12 months? Fetal death 3 Ectopic pregnancy Month Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown 9 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ⋧ σ. 1 Yes 2 No 3 Probably 4 Unknown of Vital Records, Completed 24a Was an 24b Were autopsy findings available this certificate has autopsy prior to completion of cause of performed death? Yes 2 V No Yes 2 No 25. Was case referred to medical Be 26.Place of Death (Check only one) Hospital: 1 Other<sub>4</sub> Inpatient 2 🗸 ER/Outpatient 3 1 🗸 Yes DOA Nursing Home 5 Residence 6 27. Manner of Death 28a Date of Injury FOUND: Day Year) Certification: 28b. Time of Injury 28c. Injury at Work? 28d Describe how injury occurred Division Natural FOUND: Subject pedestrian struck by vehicle within 24 hours after death To the Funeral Director: Pending Yes 2 V No 2 Accident Oct 27, 2006 1900 hrs Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 Suicide 28f Location (Street and Number or Rural Route Number, City Could not be or Town, State) Shipping PI & Center PI, Dundalk, MD determined (Specify) Parking Lot Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started Medical 2 V Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b Signature and title of certifier 29c License number 29d Date signed (Month, Day, Year) O.C.M.E October 28, 2006 104 TRyne 30. Name and address of person who completed cause of death (Item 23a) Theodore M. King, Jr., MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31 Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001 **OCME 2006** 

ORIGIÑAL

			For State Registrar	State of Ma	ryland .	-	artment of H		Mental Hyg	iene g. No. 0 (	16	34565		
	Physici	an	1. Decedent's Name (First, Middle, La		chard	Ta7a	elsh		2. Date of Deat Month	h Day	Year	3. Time of Death		
	/Media	al	4a. Facility Name (If not institution, give		Jilaiu	VVE	4b. City, Town, o	r Location of Dea	Octobe:	23, 2 4c. County		2:04 P M		
	Examir Funeral	er	317 Brookfield  5. Social Security Number 6.5	Road 7. Age	(In yrs. last	birthday)	•	asadena If Under 24 Hr	s. 8. Date of Birth	Ann	e Ar	undel Co.		
	Director		212-32-7336 Usual Residence of Decedent	MCXM 2□F	72	Yrs.	Months Days	Hours Mill	Aug.1,			nsylvania		
	yland Now		10a. State 10b. County		10c. City, T	own or Lo	cation				1	10d. Inside City Limits		
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	with the	Dire	10e. Street and Number 317 Brookfield	Road			10f. Zip Code	0110		0g. Citizen of		•		
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "natural", or Items 23e or 28e-1 ehow amy njury or other treumatic event, Ite Medical Examinant must be notified at another.	by Funeral	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1½∑Yes 2 ☐ N If Yes, Give Year or Dates:			Was Decedent of H f Yes, specify Cuba 1 ☐ Yes 2 ②No	2112 ispanic Origin? ( in, Mexican, Pue Specify:	Specify Yes or No- into Rican, etc.)	14. Rac	ck, White,	can Indian,		
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	e filed Il Hygi other vent, I	4	17. Father's Name (First, Middle, Last	)		1103	THE COLP		ame (First, Middle, I					
ylar	ould by Menta wrked	To B	John Welsh			4		<del>-</del>	lvia Tiac					
Maryland	nd 2 sh alth and 27 Is m r treum		19a. Informant's Name/Relationship ( Richard Z. Wels				g Address <i>(Street</i> East Ave		Rural Route Number alk, Mary	,	State, Zip 21222	Code)		
Baltimore,	Pages 1 and nent of Heamant: If item		20a. Method of Disposition  1  Burial 2  Cremation 3  4  Other (Speci		ceme	etery, cren	sition (Name of natory or other place Service C			20c. Location - Towsor				
Balt	permit. Departr Importa		21. Signature 15 meral Service Lice	E Ren	9_	-								
	Physician		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fedure. List only one cause on each line.  Approximat											
	/Medical Examiner		resulting in death)	Due to (or as a	ronary Artery Disease ras a consequence of): ronic Obstructive Pulmoney Disease ras a consequence of): nero scierotic Juo cular Disease							5		
	cuted	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a	consequen	ce of):	otic J	us cul	euse		1541			
8760,	ficate be executed physicien and s the burial-transit	dical Exa	resulting in death) Last	Due to (or as a	consequen	ce of):								
P.O. Box 6	The law requires that the death certific sie has been signed by the attending p page 2 should be detached for use as	Physician/Med	0								23d. Date of delivery Month Day Year			
rds, P	quires that in signed b uld be deta	ρ	Part II. Other significant conditions of Ubetto				nderlying cause giv	en in Part I.		23e. Did tobacco use contribute to the cause of de.  1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Ur				
ဝ၁	law requir as been si 2 should l	Completed	Chronic ro	enul fo	elen	e			24a. Was ar autops	24b.	Were auto	psy findings available mpletion of cause of		
<u>ه</u>	sician: The law certificete has t irector, page 2 s		Depression	ು					perforn	red?	death? 1 🗌 Yes			
<u>=</u>	s certif	o Be	25. Was case referred to medical examiner?  1 Yes 250 No	Hospital:	nt 2 🗆 ED.	Outpation	t 3 DOA Oth	0.0	eath (Check only on		(0 (			
Division of Vital Records,	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificete his completely filled in by the funeral director, page	$\vdash$	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injur (Month, Day	y 28	b. Time of Injury	28c. Injun	4   Nursing	Home 5 Seside 28d. Describe ho			<i>y)</i>		
Divis	tal or Attendests after death sel Director:	Certification:	3 ☐ Suicide 6 ☐ Could not be determined		ry - At home . (Specify)	, farm, str	eet, factory, office		28f. Location (St. City or Town	eet and Numb , State)	er or Rura	al Route Number,		
	To the Hospital or within 24 hours afte to the Funeral Dir completely filled in	Medical	one)	nysician: To the best of miner: On the basis of and manner sta	examination	dge, death and/or inv	occurred at the tin restigation, in my o	ne, date and place pinion, death occ	ce, and due to the ca curred at the time, da	use(s) and ma ite and place,	anner as si and due to	lated. the cause(s)		
	To the vithin To the comple	2	29b. Signature and title of certifier	21			29c. Licens			od. Date signer		Day, Year)		
	. 1		30. Name and address of person who	montand cause of de	ath (Item 22	la) (Tunn		3307		124	106			
16	7		MALLA MICE	outre w	10	280	09 BOST	02) STR	EET BE	ALTIM	re.	21224		
	Sta Registr		31. Date filed (Month Pay Year)	2006 32. Paistra	r's Signature	10	nach							

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygien 2005

		•	For Stete Registrar	State of Marylar	Cei	rtificate of l	Death		Reg. No		) 31	4000		
	hysicia		1. Decedent's Name (First, Middle, Las	(1)	ALP	PERT		2. Date of De Month	Da	4th ž		me of Death		
	Medic xamin	_	4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or So VO	(			c. County of D	leath April	mil		
	neral ector		5. Social Security Number 6. S 052–12–2239		last birthday)	If Under 1 Year Months Days	If Under 24 Hr Hours Mir		rth ay, Year 4, 1	919	Birthplace (S Country)	State or Foreign		
Manyland	liedat	tor	Usual Residence of Decedent  10a. State  MD  Anne A:		ty, Town or Lo	everna Pa	rk					ide City Limits		
h with the	int be notified	Funeral Director	10e. Street and Number 43 West McKinsey	Road		10f. Zip Code	146		10g. C	og. Citizen of What Country?  USA				
72 hours after deeth with the Maryland	Examiner rount be notified at	þ	11. Marital Status  1 Never Married 2 Married  3X Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 Tyes 2 Tho If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	ispanic Origin? ( in, Mexican, Pue Specify:	Specify Yes or No rto Rican, etc.)	o-		merican Indi Inite, etc. Vhite	an,		
⊆ .	event, It's Medical	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)		(Give kind of work done during most of working life. DO NOT use retired)						. Kind of Business/Industry  W York City Schools			
8 4	tic event,	To Be Co	17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Mane (First, Mane)  Dorra Caboonb							fiddle, Maiden Sumame)				
12 should th and Men	trauma		19a. Informant's Name/Relationship ( Andrea Robbins/I			ng Address (Street a			-		e, Zip Code)			
Pages 1 and nent of Health	y or other		20a. Method of Disposition 1   ☐ Burial 2 □ Cremation 3 □	20b. F	Place of Dispo cemetery, crea	osition (Name of matory or other place vid Cemet	e) Oct	Date 15, 2006	20c. l	ocation - City	or Town, Sta	ate		
permit. P	David Detroit  19a. Informant's Name/Relationship (Type, Print)  Andrea Robbins/Daughter  20a. Method of Disposition  1 Sepural 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)  21. Signature of Edneral Service Lights					2. Name and Address arranco & 95 Gov. R	erna	Park	Funera	l Home 21146				
Exan	dical niner	ler (	23a Part1. Enter the disease, or commissions, or heart failure. List only immediate Pause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate	one cause on each line.	th. Do not ent	ter the mode of dyin					Appro	eximate al Between t and Death		
Attending Physician: The law requires that the death certificate be executed releath.	prysician and the burial-transit	Medical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	quence of):									
the death certific	g) eg	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 menths? 1								delivery Day	Year		
quires thet	should be deta	Ď	Part II. Other significant conditions continuous to death out not resulting in the underlying cause given in Part I.								contribute to the cause of death?			
The law re	199 2	Completed	HPERTENSIO	N				24a. Was auto perfo 1 Ves		prior deati	to completion?	dings available n of cause of		
sician	director, pa	To Be	25. Was case referred to medical examiner? 1 ☐ Yes _ 2 ☑ No	Hospital: 1 ☐ Inpatient 2 ☐	]ER/Outpatier	nt 3 DOA Oth	05	eath (Check only only only only only only only only		6 Debar 15	Sacrific A1	F		
ath.	neral		27. Manne of Death  1 Autural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	f 28c. Injun Worl		28d. Describe			pocity) p-12			
ital or Att	completely filled in by the fu	Certification	3 Suicide 6 Could not be determined	building, etc. (Speci	fy)			28f. Location (Street and Number or Rural Route Number, City or Town, State)				Number,		
the Hospital or	npletely fi	Medical	(Check only 2 Medical Examone)	niner: On the best of my known and manner stated.	owledge, deat ation and/or in	vestigation, in my o	pinion, death occ	ce, and due to the curred at the time,	date ar	nd place, and	ner as stated. d due to the cause(s)			
V V	000	-	29b. Signature and title of certifier	A. Sprhn	am D	Print) HIGHWA		3	-	ate signed (M				
(			30. Name and address of person who	completed cause of death (Itel	m 23a) (Tyne	Print)	A					,		

Registrar
DHMH 17 Rev 1/2001

OCT 16 2006

State of Maryland / Department of Health and Mental Hygienen Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year **Physician** Ам Louise 10 Adams 2006 16 /Medical 4a. Fecility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Medical ININSULA Region of 6. Social Security Number 6. S SAUSBUKU Wicomico If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 ☐ M 2X F Director 213-24-2352 Maryland 76 1-5-1930 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits of Heelih and Mental Hygiene. Items 23a or 28a-1 ehow then 27 is marked other than "natural", or items 23a or 28a-1 ehow other traumatic event, the Medical Examinar must be notified at 10a. State 10b. County 1 ☐ Yes 2 No Wicomico Salisbury Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 203 Woodcrest Avenue USA Funeral 21801 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ∑ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status within 72 hours after 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2X No Specify: à Specify: White 3 Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker . c., Marylan.
. c., Marylan.
. d. marylan.
Department of Heelth and Mental Primportant: If Heem 27 is many Injury or other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Edward Lee Long Louise Thelma Turner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) E. William St., Salisbury, Maryland 21804 isposition (Name of 20c. Location - City or Town, State <u> Teresa Waller - niece</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Rehobeth Pres. Church 10-19-2006 Rehobeth, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Bounds Funeral Home Mion 705 E. Main Street, Salisbury, MD 21804 23a. Pgrl. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Meumonia /Medical Due to (or as a consequence of): Examiner Myocardial Infarction acute Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner physicien and the burial-transit Exacterba Box 68760, Physician/Medical for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 Ø No Month Year 4☐Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, <u>چ</u> Heart failure, Hypotensian 3 Probably 4 Unknown 1 Yes 2 No certificate has been si rector, page 2 should I Be Completed Renal Failure, Atrial 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No autopsy performed?

1 Yes 2/2 No Hypothynoidism 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 □ DOA Certification; To this 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 ☑Natural 2 ☐ Accident s after des. rei Director: After 5 Pending 1 Yes 2 No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Hospital within 24 hours at To the Funerel D completely filled i Medical Examiner: On the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basts of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 20060225 october 16, 2006 30. Name and dress of person who completed cause of death (Item 23a) Thue Print) E Canall St. Salisbury, MD MID. STEVEN HAMLETTE, 100 31. Date filed (Month, Day, Year) 32. Pigistrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Kebecca October 15 Vlarvanna yers 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Easton Hospital Memorial Talbot If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year)
August 91 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** 1 M 2 F 220-10-649 Director 91923 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ehow other traumatic event, the Medical Examiners sust be notified at MD 1 Yes 2 No Completed by Funeral Director fora 001 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Sville or iteme 23a U5A 216 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 21 Married Baltimore, Maryland 21215-0036 Specify: Black 1 Yes 2 No If Yes, Give Year or Dates: Specify "neturel", 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7:
Department of Heelih and Mental Hyglene.
Important: If item 27 is marked other then "ne eny injury or other traumatic event, the Mustice. (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Domestic Someone else's Home Work 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lee Mary Mary Margaret Dunnock

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dunnock 19a. Informant's Name/Relationship (Type, Print) 4637. Harrisville Rd.P.O. BOX/31\_ Woolford, MD. 21677 Stanle Ona 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Yown, State 1 Burial 2 Cremation 3 Removal from State 10/20/06 4 ☐ Donation 5 ☐ Other (Specify) Malone Cemetery 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 23a. Party Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. 2/6/3 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician CHRONIC MYZLOGENOUS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence Examiner physicien and is the buriel-transit or Attending Physicien: The law requires that the death certificate be executed etubo Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medicai IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ♠ No Month Year Dav 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 🗌 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 2 X No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death | Check only one Hospital: Inpatient 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient this 3 DOA Certification: 27. Manner of Death 28a. Date of Injury (Month, Day Year) After t 28b. Time of 28c. Injury at 28d. Describe how injury occurred s after dec. ral Director; After 1 Natural 5 Pending 2 Accident investigation 1 Yes 2 No 6 Could not be determined 3 🗍 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funeral D Hospite Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Hedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier To the Signature and title of 29d. Date signed (Month, Day, Year) 29c. License number and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

219 S. Washington St., Easton, MD

Jakers-Matzoni, Do

31. Date filed (Month, Day

32. Registrar's Signature

			1 - State of Maryland / Dep	eartment of Health and Nertificate of Death	Mental Hygier	211116	34569				
			Decedent's Name (First, Middle, Last)		2. Date of Death	***************************************	3. Time of Death				
	Physici /Medic		Robert Bernard Bowytz		October	15, 2006	2:15 A M				
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death					
			The Casey House	Rockville		Montgomer	У				
E	Funeral Director		5. Social Security Number 6. Sex 176-30-1875 6. Sex 1 № 2□ F 68 7. Age (In yrs. last birthday 6. Sex 1 № 68 7. Age (In yrs. last birthday 6. Sex 6. Sex 1 № 68 7. Age (In yrs. last birthday 6. Sex 6. Sex 1 № 68 7. Age (In yrs. last birthday 6. Sex 1 № 68 7. Age (In yrs. last birthday 6. Sex 1 № 6	If Under 1 Year   If Under 24 Hrs.   Months   Days   Hours   Min.	8. Date of Birth (Month, Day, Yes April 21,	9. Birth Cou 1938 PA	place (State or Foreign ntry)				
	and *		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or I	ocation			10d. Inside City Limits				
	Aaryl r eho	ច	MD Montgomery Chevy Ch				11⊠Yes 2 No				
	the 1	rect	10e. Street and Number	10f. Zip Code	100.0	Citizen of What Cou	ntry?				
	within 72 hours atter deeth with the Maryland ene. then "natural", or iteme 23a or 28a-f ehow the Madical Examiner must be notified at	by Funeral Director	4615 N. Park Ave. #304	20815		U.S.A.	,.				
	me 2	era	11. Marital Status 12. Was Decedent Ever in U.S. 13	. Was Decedent of Hispanic Origin? (Sp	ecify Yes or No-	14. Race - Ameri	can Indian,				
က	or fte	Ē	Armed Forces? 1 □ Never Married 2 ☑ Married 1 ☑ Yes 2 □ No	If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Black, White,					
8	raff, c	by	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Vietnam Year or Dates:	1 ☐ Yes 2 ☒ No Specify:		Specify:	White				
5-0	72 ho	Completed	15. Decedent's Education 16a. Dec (Specify only highest grade completed) (Giv	edent's Usual Occupation e kind of work done during most of work	16b.	Kind of Business/In	ndustry				
2	ithin	du	Elementary/Secondary (0-12) College (1-4or 5+) // Δ +	DO NOT use retired) torney		Law					
2	led w lygier her ti	S	4+								
ano	ntal H ad off	Be	17. Father's Name (First, Middle, Last) Harry Bowytz	Marion	e (First, Middle, Maid Moss	en Sumame)					
Ž	d Mei d Mei mark	ဥ					0-1-1				
, Ma	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Depertment of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Iteme 23a or 28a-f show any injury or other traumatic event, the Madical Examiner must be notified at anone.		Sheila Footer- Wife 4615	ling Address (Street and Number or Rur N. Park Ave. #304							
ore	of He		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition cemetery, cr	ematory or other place)	Date 20c.	Location - City or To	own, State				
Ē	Pag ment ant: ury		4 □Donation 5 □ Other (Specify) Judean			lney, MD					
園	npodu ny in			22. Name and Address of Facility Edv	_						
-	40 5 e d			1091 Rockville Pik		e, MD 208	52				
			23a. Part1. Enter the disease, or complications that caused the death. Do not enshock, or heart failure. List only one cause on each line.	nter the mode of dying, such as cardiac	or respiratory arrest,		Approximate Interval Between Onset and Death				
	Physician		Immediate Cause (Final disease or condition End Stage Liver I	Disease		1	Criser and Death				
	/Medical Examiner		resulting in death)  Due to (or as a consequence of):								
		_	Sequentially list conditions b Cryptogenic Live Due to (or as a consequence of):	er Cirrhosis							
_	pet lisit	Examine	cause. Enter Underlying Cause (Disease or injury								
	and al-tra	xar	that initiated events c			-					
8760,	cate be executed physicien and the burial-transit	dical	4								
9	tificat ng phy as the	edic									
Вох	eath certifi attending     for use as	2	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death 3			23d. Date of delive	ery				
<u>.</u>	deat	sicla	1 Yes 2 No	☐Ectopic pregnancy ☐ Other (specify)		Month	Day Year				
<u>Р</u> О	thet the de ed by the detached	Physician/Me	9 Onknown								
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၀	sw requires s been si	olete	Coronary Artery Disease		24a. Was an	24b. Were auto	opsy findings available				
æ	The lav	Completed	ordinary meet passess		autopsy performed? 1 Yes 2 ☑ 1	? death?	mpletion of cause of				
ital	icien: Th certificete rector, pag	0	25. Was case referred to medical	26. Place of Deat	h (Check only one)	10 103	223110				
>	\$ .v = 0	To B	examiner? 1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient	104	me 5 Residence	6 ☐Other (Special	(v)				
0	ng Ph ter th neral		27. Manner of Death 1 ⊠Natural 5 □ Pending 28a. Date of Injury (Month, Day Year) 1 njury		28d. Describe how in						
<u>~</u>	Attending in death.	ät	2 Accident investigation	M 1 ☐ Yes 2 ☐ No							
Division of Vital Records,	at or Att	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	treet, factory, office	28f. Location (Street City or Town, Sta		al Route Number.				
	To the Hospital or Attending Phwithin 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical	29a. Certifier  (Check only one)  1 Certifying Physician: To the best of my knowledge, dea 2 Medical Examiner: On the basis of examination and/or and manner stated.	ith occurred at the time, date and place, nvestigation, in my opinion, death occur.	and due to the cause red at the time, date a	e(s) and manner as s and place, and due to	tated. o the cause(s)				
	To the within 2 To the complet	Me	29b. Signature and title of certifier	29c. License number	29d. (	Date signed (Month,	Day, Year)				
			Rignikie m Dulliams Do	H0058032	. 0	ctober	15, 2006				
	O		30. Name and address of person who completed cause of death (Item 23a) (Type				,				
			Cynthia M. Williams, D.O. 6001 Mun		ckville, M	D 20852					
	Sta		31. Date filed (Month, Day, Year)  OCT 17 2006  32 Registrar's Signature	acti i							
	Registr	ar	OCT 17 2006 Regues & B								

State of Maryland / Department of Health and Mental Hygiene. Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) 3. Time of Death Day Month Year **Physician** 3:48P M October 13, 2006 /Medical Myrtle Mayleen Bacchus 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Silver Spring
If Under 1 Year | If Under 24 Hrs. Holy Cross Hospital Montgomery Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5 Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months Hours 1 ☐ M 2 ☑ F Yrs. Director 578-76-1466 58 May 17, 1948 Guyana Usual Residence of Decedent 10c. City, Town or Location 10b, County 10d. Inside City Limits 28a-f ehow the Medical Examiner must be notified at 1 Tyes 2 No Director Maryland Montgomery Wheaton 10e. Street and Number 10f. Zin Code 10g, Citizen of What Country? or fleme 23s or 11101 Georgia Aveneue, Apt. 509 20902 USA Funeral deeth 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black. White, etc. filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes Ž No Specify: Black Specify. þ 3 Widowed 4 Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) other than College (1-4or 5+) Cook Hospital perfet. Pages 1 end 2 should be filed Department of Heelth and Mental Hyg Importent: if Item 27 is marked other eny injury or other treumatic event, 17 Father's Name (First Middle Last) 18 Mother's Name /First Middle Maiden Sumame: Be George Rupert Bacchus Millicent Agatha Ince 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sarah A. Bacchus/ Daughter 11101 Georgia Avenue, # 509, Silver Spring, MD 20902 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 21, October 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2006 Silver Spring, Maryland Gate of Heaven Cemetery 22 Name and Address of Farthy. Francis J. Collins Funeral Home Inc. 21. Signature of Funeral Service Licensee 500 University Blvd, W, Silver Spring, MD 20901 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failute. List only one cause on each line. 23a. Part1. Enter Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Pnysician Pneumonia resulting in death) /Medical Due to (or as a consequence of): **Examiner** Breast Cancer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): attending physicien Box 68760 Physician/Medical es the t nse i IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No ģ Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) P.O. 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ş 99 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown certificate hes been si rector, page 2 should i Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 Tes 2 No 1 Yes 2 No or Attending Physician: funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA this 27. Manner of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending i efter death. ii Director: Afi ed in by the fur 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - Al home, farm, street, factory, office building, elc. (Specify) filled in by 4 Homicide To the Hospital or within 24 hours of To the Funeral D 1 Ccrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) , MD on time Do0 62488 10/13/06 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Pratima Pathak, M.D 1500 Forest Glen Road, Silver Spring, MD 20910 Registrar's Signature 31. Date filed (Month, Day, Year) State 7 2006 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death ENRY Physician 70 2000 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 225 Burns Crossing Road Severn Anne Arundel If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 ∰ M 2 ☐ F 83 Yrs 216-18-5855 Feb 27 1923 Director Tennessee Usual Residence of Decedent 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits 28a-f show the Madical Examiner must be nutified at 1 ☐ Yes 2√ No Director Anne Arundel Severn 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or items 23a or 225 Burns Crossing Road 21144 USA death. Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1XX Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes XXNo Specify: Specify: White þ 3 Widowed 4 Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry other than Elementary/Secondary (0-12) College (1-4or 5+) LPN permit. Pages 1 and 2 should be filed w Department of Heelth and Mental Hygier Important: If Item 27 is marked other th any injury or other traumatic event, the 2008. Nursing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Tivis Bell Elsie Bell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda Caldwell (Sister) 231 Burns Crossing Road, Severn, MD 21144 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Glen Haven Cemetery | 10-12-2006 | Glen Burnie, MD 21. Signature of Funeral Service Conse 22. Name and Address of Facility
Hardesty Funeral Home, P.A. 12 Ridgely Avenue, Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) EPATOMA **Physician** 6mon /Medical Due to (or as a consequence of). Examiner Sequentiafly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physiclen and for use as the burial-transit the Hospital or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Hospital: 1 Inpatient Other: 4 Nursing Home 5 Fesidence 6 Other (Specify) 1 Yes 2 Ko ဥ 2 ER/Outpatient 3 DOA this 27. Manner of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: After 5 Pending Injury efter death.

Director: Aff 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 ☐ Suicide 28e. Pface of fnjury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide completely filled in To the Hospital within 24 hours e Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

I medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) 29b. Signature and title of certific 29c. License number 29d. Date sigged (Month, Day, Year) D 21438 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Michael J. LaPenta, MD, Hospice of the Chesapeake, 445 Defense Hwy, Annapolis, MD 31. Date filed (Month, Day, 200 Begistr & Signature 21401 State 16 Registrar

		4	For State Registrar	State of M	aryland /	•	artment rtificate			and M		giene Reg. <b>2</b> . 0	06	345	72
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	Physici /Medic		1. Decedent's Name (First, Middle, Last)  Carl Thomas Barrett				2. Date of Death OCMOBER	Day Year 3 2006	3. Time of Death 10:20 A M
	Examin	er	4a. Facility Name (If not institution, give street and number)  St. Mary S Hospital  5. Social Security Number 6. Sex 7. Age (In yrs.	In a t hirthelm of	Leonard		P. Date of Righ	4c. County of Deat	ry's
	Funeral Director		219-16-1647 1 2 F 83	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, Aug 29	Year) Co	hplace (State or Foreign untry) ryland
	Maryland -f ehow lied at	tor	10a. State 10b. County 10c. Ci	ity, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 No
	h with the	al Director	10e. Street and Number 251 Driftwood Lane		10f. Zip Code 20688	}		g. Citizen of What Co	
036	s 1 and 2 should be filed within 72 hours after deeth with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "neturet", or iteme 23e or 28e-f ehow other traumatic event, the Medical Exporter grant be notified at	by Funeral	11. Marital Status  1 Never Married 2 Narried  3 Widowed 4 Divorced  12. Was Decedent Ever in UAmed Forces?  Yes 2 No If Yes, Give Year or Dates:		Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 No	ispanic Origin? (Sp In, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit Specify: Wh	
Baltimore, Maryland 21215-0036	d within 72 ho giene. In then netur	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  1 2 th  College (1-4or 5+)	(Give	dent's Usual Occupi kind of work done of DO NOT use retired ctor of	during most of work f) Houseke	eping		Memorial
ryland	should be filed and Menta! Hygi s marked other umatic event, II	To Be C	17. Father's Name (First, Middle, Last)  Daniel Barrett  19a. Informant's Name/Relationship (Type, Print)	10h Maili	na Addross (Street	Annie	Allen	aiden Sumame)	
e, Ma	1 and 2 s Health an em 27 is r ther traur		Beverly R. Barrett- wife	251 I	Driftwood	Lane Sol	omons MD		
timor	Page nent o ant: If ury or		1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	cemetery, crer . Paul U	matory or other place MC Cenetiery	e) Oct 18 20	M6	sby, Marylar	
Ba	permit. Departr importr eny inj		21. Signature of Funeral Service Licensee	44	2. Name and Address 405 Broomes	Is. Rd. Po		c MD 20676	
>	Physician /Medical		23a. Part1. Enter the disease, or complications that caused the dea shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consection or condition resulting in death)	akry	Phe	ug, such as cardiac	or respiratory arres	st,	Approximate Interval Between Onset and Death
,00	icate be executed by physicien and burial-transit by	l Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b. Due to (or as a consection of the		emen	7 / 4			>341
P.O. Box 68760,	death certifi e ettending ed for use as	Physician/Medical	d	al death 3	□Ectopic pregnancy □ Other (specify)	, N/A		23d. Date of de Month	ivery Day Year
	8 5 6	Ď	Part II. Other significant conditions contributing to death but not re	sulting in the u	underlying cause giv	en in Part I.		acco use contribute to	the cause of deam?
Division of Vital Records,	The law ete hes b page 2 s	Completed	M. Prosture Cancer				24a. Was an autopsy perform	prior to death?	utopsy findings available completion of cause of 2 No
f Vita	Physician: 1 this certificed ral director, p	To Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☑ No Hospital: 1 Vinpatient 2 ☐	☐ ER/Outpatier	nt 3□ DOA Oth	or	th Check only one	nce 6 ☐Other (Spe	city)
sion of	ath. ath. or: After		27. Manner of Death 1 Natural 5 Pending (Month, Day Year) 2 Accident investigation	28b. Time o Injury	of 28c. Injur		28d. Describe how		
Divis	To the Hospital or Attent within 24 hours after death To the Funaral Director: completely filled in by the	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At homicide building, etc. (Special Could not be determined 28e. Place of Injury - At homicide building, etc. (Special Could not be determined 28e. Place of Injury - At homicide 28e. P	eify)			City or Town,		
	the Hosp in 24 hou the Funal ipletely fil	ledical	79a Certifier (Check only one)  Certifying Physician: To the best of my one one)  Certifying Physician: To the best of my one one of the basis of examiner: On the basis of examiner and manner stated.	iowladge, deal lation and/or in	nvestigation, in my o	pinion, death occur	red at the time, da	te and place, and due	to the cause(s)
	with To COT	Σ	29b. Signature and title of certifier	70	29c. Licens	62213		oli Hof	h, Day, Year)
_	6+1		30. Name and address of person who completed cause of death (lite DR.SURESH H. PATEL SHAH ASSOC.	. 22650		ANE COURT	LEONARD	TOWN MD 20	650
	Sta Regist		31. Date filed (Month, Day, Year)  32. Registra's Sign  OCT 1 7 2006		Sparte	,			

CARL THOMAS BARRETT

			ForState	State of Marylan				Mental Hy	giene	0 01.575
			Registrar  1. Decedent's Name (First, Middle, Last	)	Certi	ficate of L	Death	2. Date of Dea	Reg. No. UU	3. Time of Death
	Physicia /Medic		Nichol As	Frank		BA	RNES	Detabe	Day Y	ear 2/
	Examin		4a. Facility Name (If not institution, give	street and number)	1//	b, City, Town, or	Location of Death		4c. County of	Death
	Eugevel		5. Social Security Number 6. Se	7. Age (In yrs.	last birthday)	If Under 1 Year	ore If Under 24 Hrs.	8. Dale of Birt		More.  D. Birthplace (State or Foreign
	Funeral Director			<b>2</b> M 2□ F	Yrs.	Months Days	Hours Min.	8. Dale of Birt (Month, Da	2006 /	Maryland
	and w		Usual Residence of Decedent  10a. State 10b. County	10c. Cit	y, Town or Loca	tion				10d. Inside City Limits
	Mary -1 eh	tor	MA NIA		NIA.					1 Tyes 2 No
	or 28	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of Wh	
	leath v	Funeral	N/A 11. Marital Status	12. Was Decedent Ever in U	.S. 13. Wa	N A	spanic Origin? (S	pecify Yes or No	United 14. Bace	States American Indian.
٥	after or iten	Fun	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give	lf Y	es, specify Cubai Yes 2 □ No	Specify:	o Rican, etc.)	Black,	White, etc.
5-0036	within 72 hours after death with the Maryland lene. Ithan "natural", or items 23a or 28e-f ehow the Madical Examinar must be notified at	ed by	3 ☐ Widowed 4 ☐ Divorced  15. Decedent's Edu	Year or Dates:		nt's Usual Occupa				White
ָל הלי	hin 72 In "ne Medic	Completed	(Specify only highest grad	College (1-4or 5+)	(Give kii		luring most of wor	rking	16b. Kind of Busi	ness/industry
2	D 00 2		NIA			NIA			WIA	
Maryland	e d in o >	То Ве	17. Father's Name (First, Middle, Last)  Cordairo	, Barnes			Eric		Wright	
ary	2 should and Men ie marke aumatic	-	19a. Informant's Name/Relationship (T)		19b. Mailing	Address (Street a			er, City or Town, St	
	s 1 and 2 shou f Heelth and M Item 27 ie mar other traumat		Erica L. Wrigh  20a. Method of Disposition		401 A		treet,	Hurlock	20c. Location - C	21643
altimore,	m O h-		1 Surial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify)	Removal from State	semetery, crema	hington (				Maryland
<u>=</u>	permit. Page Department Important: If eny injury o		21. Signature of Funeral Service Licens						Funera	
	88 5 8		Michael +	. Eskon	21	6 N. Ma	ain St.	Feder	als burg,	MO 21632
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only o Immediate Cause (Final	ications that caused the deat ne cause on each line.				,		Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. Disseming	Jed juence of):	HELPES	Single	14 V12	us	9 dely5
п	Examiner	_	Sequentially list conditions,	b. —						
	uted d ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a conseq	uence or):					
o,	sate be executed bhysiclen and the burial-transit		resulting in death) Last	Due to (or as a conseq	uence of):	-				
98760	certificate be executed nding physiclen and use as the burial-transit	dical	•	d				<del>-</del> ,,		
Box 6	eeth certific ettending p	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna				-	23d. Date	of delivery
	σ o σ	Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d 9 ☐ Unknown		ctopic pregnancy other (specify)			Month	h Day Year
P. 0.	The law requires thet the de ole hes been signed by the e page 2 should be detached f		Part II. Other significant conditions co	ntributing to death but not res	ulting in the und	erlying cause give	en in Part I.	23e. Did t	obacco use contrib	tute to the cause of death?
Division of Vital Records,	w requires been sign should be	Completed by	Encephalitis					101	res 2 No 3	Probably 4 Unknown
eco	law requires been	nplet	LIVER FAILUCE					24a. Was	an 24b. We	ere autopsy findings available or to completion of cause of
<u>в</u>		Con	KENAL FAILURG 25. Was case referred to medical	s <sup>2</sup>					rmed? _   dea	ath? ]Yes 2∐ No
Ξ	ysicia is certi directo	To Be	examiner?	Hospital: 1 Inpatient 2	ER/Outpatient	3□ DOA Othe	20	ath (Check only o lome 5 ☐ Resid	ne) dence 6 ∐Other	(Specify)
0	ding Ph h. After th funeral		27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work			now injury occurred	
isio	tten deatl stor:	ficat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - At h	ome farm stree		Yes 2 □No	28f. Location (	Street and Number	or Rural Route Number,
2	rs after d ai Direct ed in by	Certification:	4 Homicide determined	building, etc. (Specil	(y)	a, radiory, omoo		City or Tov	vn, State)	o maran issue manager,
	To the Hospital or A within 24 hours after To the Funeral Direct completely filled in by	edicai	29a. Certifier 1 ☐ Certifying Phy (Check only one)	rsician: To the best of my kno iner: On the basis of examina and manner stated.	owledge, death outline ation and/or inve	occurred at the tim stigation, in my of	ne, date and place pinion, death occu	e, and due to the urred at the time,	cause(s) and manr date and place, an	ner as stated. d due to the cause(s)
	To the within To the comple	Me	29b. Signature and title of certifier			29c. License	number		29d. Date signed (	(Month, Day, Year)
)			Marisse fo	runettiple		RES.	-000		Detobes	17,7006
			30. Name and address of person who of Manissa Brun		n 23a) (Type, P	int)	(+ B)	Hines	a Marie	17, 2006 land 21287
	Sta		31. Date filed (Month, Day, Year)	32. Registre's Signa	ature	1	1 / 19	11.19000	; JUIPIZY )	1711 6160
	Registr	ar	001 1 0	LUUU JEEGGAR	15.	60340				

	_	For State Registrar	State of Ma	aryland	d / Depa <i>Cer</i>	rtmen tificate	of H	ealth a	and M		1.03.11	200	) 6	34576
Physiciar		<ol> <li>Decedent's Name (First, Middle, Las Marjorie</li> </ol>	Roberta		Brisba	ano				2. Date of Do Month Octobe	eath r 16	ay 20	Xear	3. Time of Death 7:10 am
/Medica Examine		4a. Facility Name (If not institution, give			DLISO		Town, or	Location	ol Death	OCTOBE			of Death	7.10 all
Examine	ı	Northampton Manor		Cente	er		eder						leric	k
Funeral Director		5. Social Security Number 6. Social Security Number 104-26-7047 1  Usual Residence of Decedent	9x □ M 2 <b>X</b> F	9 (In yrs. la 72	ast birthday) Yrs.	If Under Months	1 Year Days	II Under Hours	24 Hrs. Min.	8. Date of Bi (Month, Di Nov 24	rth ay, Year 1	33	9. Birthp Cour New	place (State or Foreigntry). York
Maryland -f ehow		10a. State 10b. County	erick	10c. City	, Town or Lo	ration Fred	lerio	ck					1	0d. Inside City Limits
th with the 23a or 28a	al Dile	10e. Street and Number 200 East 16th St	reet			10f. Zip	<sup>Code</sup> 217	01			10g. C	itizen of V	Vhat Cour	ntry?
Baltimore, Maryland 21215-0036  permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Heelth and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23a or 28a-1 show any injury or other traumatic event, the Medical Evandrat must be rediffed at once.	no Lange	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Decedent I Armed Forces? 1 ☐ Yes 2 🐼 N If Yes, Give Year or Dates:			Was Deced f Yes, spec		spanic Ori n, Mexicar Specify:		ecify Yes or N Rican, etc.)	0-	Blac	e - Americ k, White, :: Whi	
Baltimore, Maryland 21215-0036 sernit. Pages 1 and 2 should be filed within 72 hours all oppartment of Heelth and Mental Hygiene. Importent: If tem 27 is marked other then "natural", or my injury or other traumatic event, the Medical Event to the filed of the filed for the filed fo	Dinplete	15. Decedent's Ed (Specify only highest gra- Elementary/Secondary (0-12)	lucation de completed) College (1-4or 5 2	i+)		lent's Usua kind of wor DO NOT us Le Cl	k done d e retired	ation luring mos )	t of work	ing			isiness/In	
yland Sould be filed Mental Hygarked otheratic event.	2000		ardiner						or's Name	e (First, Middle	, Maide	n Sumam	Dug	gan
Mar and 2 sho selth and n 27 fs m		19a. Informant's Name/Relationship (7 Kenneth Brisbane,			7016	Mead	ow R	idge		Nashvi				ee 37221
Pages 1 Pages 1 nent of He ent: if ter		20a. Method of Disposition  1 23 Burial 2 □ Cremation 3 □  4 □ Donation 5 □ Other (Specify		20b. Pl	ace of Dispo emetery, cren Olivet	sition (Name that one of the Cemes Cemes	e of her place tery	<sub>e)</sub> 7 Oc		, 2006			-	own, State Iaryland
Balt permit. Departr import eny inji		21. Signature of Funeral Service Licen	Bew	MOO <b>7</b> C	)67 <b>1</b> (	NaKeei 06 Eas	Addres ney st C	e Bas hurch	force St.	l P.A. Frede	Fune rick	ral . Ma	Home rvla	nd 21701
Physician /Medical Examiner		23a/Part. Enter the disease, or complished, or heart lailured List only of the complete states of the complete sta	a. Alzheil  Due to (or as:  Due to (or as:	mer s a consequ	s Demei		o o ayını	g, such as	cardiac	or respiratory a	irrest,			Approximate Interval Between Onset and Death Years
76( nte be nysicie	2	resulting in death) Last	Due to (or as:	a consequ	ience of):									
Vision of Vital Records, P.O. Box 68 Attending Physician: The law requires that the death certificate sector: After this certificate hes been signed by the attending ph by the funeral director, page 2 should be detected for use as it	I yalcıdı Divic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2X□ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal	death 3	Ectopic pro						23d. Dat Moi	e of delive	ory Day Year
rds, P		Part II. Other significant conditions of	ontributing to death be	ut not resu	ilting in the ur	nderlying ca	use give	en in Part I			tobacco Yes 2			ne cause of death? ably 4 DUnknown
Division of Vital Records, or attending Physician: The law requires to fire death. Director: After this certificate has been signed in by the funeral director, page 2 should be certification: To Reformulated by		25. Was case reterred to medical								1 ☐ Yes	psy ormed? 2 X No	1 5	Vere auto prior to con death?	psy findings available πpletion of cause of 2 ☐ No
of Vita hystoian his certifi il director	2	examiner?	Hospital: 1 ☐ Inpatie	nt 2 🗆 E	ER/Outpatien	t 3□ DO	Othe			n <i>(Check only</i> me 5□ Res		6 ∏Oth	er (Specifi	v)
ion of anding Ph ath.		27. Manner of Death  1 XNatural 5 Pending 2 Accident investigation	28a. Date of Injur (Month, Day		28b. Time of Injury		c. Injury Work	at		28d. Describe				<u> </u>
Division of Vital Receipts to the Hospitel or Attending Physician: The law within 24 hours effer death. To the Funeral Director: Affer this certificate has completely filled in by the funeral director, page 2		3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injubulding, etc	ury - At hor c. (Specify	me, farm, stre	eet, lactory	office			28I. Location ( City or To			er or Rura	l Route Number,
Dive Hospitel or thin 24 hours effe or thin 24 hours effe or the Funeral Dir mpletely filled in 1		29a. Certifier  (Check only one)  1 ☒ Certifying Phylogenesis (Check only one)	ysician: To the best of niner: On the basis of and manner sta	examinati	vledge, death ion and/or inv	occurred a	it the tim	e, date an pinion, dea	d place, th occurr	and due to the ed at the time,	cause(s	and ma d place, a	nner as st and due to	ated. the cause(s)
To the within 2 To the complet		29b. Signature and Merchier	and marrier sta	<u> </u>		29c	License D26	number 499						Day, Year) 2006
10		30. Name and addless of person who of Ronald Miller, M.							Mary	land 2			,	_
State Registrar		31. Date liled (Month, Day, Year)	32. Registra			and s	.c A	y <b>,</b>	y		_, / _	•		

DHMH 17 Rev 1/2001

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

	1	For State Registrar			•	ertificate of I			Reg. Ne	006	31.57	77
Physician		Decedent's Name (First, Middle Sther Cole	e, Last)					2. Date of De 10/10	CLLII	Year	9. Time of De 2:00P	ath M
/Medical Examiner	4	la. Facility Name (If not institution Holy Cross Hos		umber)		4b. City, Town, or Silver S	Location of Death		4c. C	ounty of Death		
Funeral Director		018–40–3482	6. Sex 1 ☐ M 2 <b>X</b> F	7. Age (In yrs. 94	. last birthday Yrs.	y) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir	<sup>†</sup> 1911	9. Births Cour	place (State or Fo	oreign
a-f show tifled at ctor	Į	Usual Residence of Decedent  10a. State 10b. County	tgomery		ity, Town or l					1	0d. Inside City L	
23a or 28a-f st 1st be notified al Director	1	9523 West Sta	anhope Ro	ad		10f. Zip Code 2089	5		10g. Citize	en of What Coul		
permit. Tagges I and a Should be filed within 72 hours after death with the liviarylan Department of Health and Mental Hyghene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.  To Be Completed by Funeral Director		11. Marital Status 1	Armed	3 2 (₹ No Give	J.S. 13	3. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	ispanic Origin? (Sp an, Mexican, Puerto Specify:	pecify Yes or No Rican, etc.)		Race - Americ Black, White, Specify:		<u>.</u>
ygiene.  ner than "natura ner than "natura t, the Medical E Completed	-	15. Deceder (Specify only higher Elementary/Secondary (0-12)	<del> </del>	d) (1-4or 5+)	(Giv	cedent's Usual Occup ye kind of work done of DO NOT use retired nistrator	during most of work	king	Brand	of Business/In leis Uni ns Commi	versity	,
Mental Hy Mental Hy arked othe atic event, To Be C		17. Father's Name (First, Middle, Robert Rich	Last)				18. Mother's Nam Sarah	e (First, Middle Melman	, Maiden S	urname)		
and z sing ealth and I m 27 is ma her trauma		19a. Informant's Name/Relations  James J. Rich			9523	iling Address (Street West Sta	nhope Roa	d Kensi	ingtor	1 MD 208	95	
tment of H tant: If Itel		20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation  4 ☐ Donation 5 ☐ Other (S	Specify)		cemetery, ci aron M	position (Name of rematory or other plac [emorial Po —	ark 10/	Date 13/06	Sha	ation - City or To	ıss	
Depart Import any in		21. Signature of Funeral Service	Licensee			22. Name and Addre						.on
Physician /Medical		23a. Part1. Enter the disease, o shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	t only one cause or aM	each line.	c Ence	enter the mode of dyir		or respiratory a	arrest,		Approximate Interval Betwee Onset and Dea	en ath
an and rial-transit Examiner		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	D. Due t	epsis o (or as a conse							_	
intificate be executed ing physician and as the burial-transit.		resulting in death) Last	Due t	o (or as a conse	quence of):							
ines that the death certified signed by the attending plug be detached for use as the by Physician/Med		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 ☐Liv	outcome pf pregrebith 2 February Februa	tal death	3 □Ectopic pregnanc) 5 □ Other (specify) _	,		23	d. Date of deliverships Month	ery Day Yea	ar
law requires mat as been signed b 2 should be deta	١.	Part II. Other significant conditi	ons contributing to	death but not re	sulting in the	underlying cause giv	en in Part I.		tobacco us		he cause of dea	
ate h		OF Weep and referred to madic						1□ Yes	ormed?		psy findings ava mpletion of caus 2 No	
hysiciar this certif al directol	1	25. Was case referred to medica examiner? 1 ☐ Yes 2 ☐ No	Hospital	▼inpatient 2[	☐ ER/Outpati	ient 3 DOA Oth	er: 4 ☐ Nursing H			□Other (Specia	fy)	
ending Fri ath. or: After th he funeral		Z E Moddellt	ng (Mi igation	te of Injury onth, Day Year)	28b. Time Injury	y Wor		28d. Describe				
risa for Attending and a state of the form of the function. After led in by the funer.  Certification:		3 Suicide 6 Could 4 Homicide detern	nined   28e. Pla	ce of injury - At I ilding, etc. (Spec		street, factory, office	Y		(Street and own, State)	Number or Run	al Route Numbe	<i>₹</i> ,
to the nospiral or Attending Prysican: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director,  Medical Certification: To Be C		(Check only 2 Medical one)	Examiner: On the and m	the best of my kr e basis of examir anner stated.	nowledge, de nation and/or	eath occurred at the till investigation, in my o	opinion, death occu	, and due to the rred at the time	, date and	place, and due t	o the cause(s)	
D C T with			na cra			29c. Licens D6082				signed (Month,	- /	
		30. Name and address of person  Kshama Gar		· ·	, , , , ,	,	ver Sprin	g MTD 20	910			
State Registrar		31. Date filed (Month, Day, Year OCT 1	) 32	. Pjegistrar's Sign	nature		ACT DALTH	.6 III 20	,,,,,,	-		

**ORIGINAL** 

DHMH 17 Rev 1/2001

DHMH 17 Rev 1/2001

21215-0036

Maryland

Baltimore,

P.O. Box 68760.

Division of Vital Records,

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene Ronald James Dryden

		1- For State Certificate of Death		Reg	No and	c 01 E00
Physicia	an/	1. Decedent's Name (First, Middle,Last) Revold James Drydon		2. Date of Death Month	Day Year	3. Time of Deate 0
Medical Exami	ner	Ronnie James Bryden Ronnie James  4a Facility Name (if not institution, give street and number)  4b City, Town	Dryden n, or Location of Death	Month Cotober 23,	2006 4c. County of Dea	1628 hrs
		1201 Mount Heron Road Salisburg			Wicomico	atti
Funeral Director		5. Social Security Number 215-72-3065 6. Sex 7. Age (In yrs. last birthday) If Under 1 41 Yrs. Months	Year If Under 24Hrs.  Days Hours Min.	8. Date of Birth 08/17/		Birthplace (State or Foreign Country) aryland
ń		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location				10d Inside City Limits
J Iow any		Maryland Wicomico Salisbury				1 X Yes 2 No
daryland 28a-f show 1 at once.	Director	10e. Street and Number 10f. Zip Coo	de	10g	. Citizen of What Co	
hours after death with the Maryland 'natural', or items 23a or 28a-f she Examiner myst be notified at once	Öire	2726 Refuge Lane 218	304		USA	
th with	Funeral		f Hispanic Origin? (Speuban, Mexican, Puerto R		14 Race - Am White, etc.	erican Indian, Black,
ter dea		1 Yes 2 X No	No specify:	,	Specify	white
ours af	g	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occ	upation (Give kind of wo		6b. Kind of Busines	
C1	Completed by	Elementary/Secondary (0-12) College (1-4 or 5+)	life. DO NOT use retire	(d)	Deinting	
5-0036 ed within 72 tygiene other than "	mo	10 – Painter  17. Father's Name (First, Middle, Last)	18 Mother's Name (	First Middle Ma	Painting	
21215-0036 sold be filed within 7 Mental Hygiene marked other than c event, the Medica	Be C	Woodrow Ronnie Dryden		Ann Davi	, , , , , , , , , , , , , , , , , , , ,	
AD 2 shc 1 and 27 is	2	19a Informant's Name/Relationship (Type, Print ) Woodrow R. Dryden/father  19b. Mailing Address (S 26402 Big N	Street and Number or Rullill Rd., Go	ral Route Number	er, City or Town, Sta vn, DE 199	ate, Zip Code) 947
ore, N s I and of Health If item		20a Method of Disposition  1 X Burial 2 Cremation 3 Removal from State 20b Place of Disposition (Name of Crematory or other place)	f cemetery,	Date 2	20c. Location - City	or Town, State
Baltimore, permit Pages I an Department of Hea Important: If iter injury or other tra		4 Donation 5 Other Specify: Franklin City C				kville, VA
		21. Signature of Funeral Service Ilcensee  Loud Routiney (TS)  22. Nema and Add Holl Towns 501 Snc	hy funeral l w Hill Rd.	Home Pro , Salish	ofessional oury, MD 2	l Association 21804
Physician /Medical		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dy failure. List only one cause on each line.	ring, such as cardiac or r	espiratory arrest	t, shock, or heart	Approximate Interval Between Onset and
Examiner		Immediate Cause (Final disease or condition resulting in death)  Arcotic intoxication  Due to (or as a consequence of):	SUE 1 5 1	<del></del>		Death
	۰	Sequentially list conditions, b.				
	Examiner	if any, leading to immediate cause Enter Underlying Cause (Disease or injury that initiated C				
cuted und transit		events resulting in death) Last Due to (or as a consequence of):  d				
760, cate be execut physician and he burial - trai	/Medical	x unpended #1, perME, G863, 1/16/07 T #23a, 27, 28a-f, perME, g861, 1	T 1/21/06 TT			
8760, iificate be ng physic		IF FEMALE. 23c. If yes outcome of pregnancy 1	3 Ectopic pregnance	cv	23d Date of deliver	Day Year
, P.O. Box 68 res that the death certifus signed by the attending be detached for use as	Physician	past 12 months?  4 Pregnant at time of death 5 Other (Specify)	program	-,	Month	Day Toal
). Bc the dea	Phy	Part II. Other significant conditions contributing to death but not resulting in the underlying cau	ise diven in Part I	23e Did tobs	acco use contribute t	to the cause of death?
P.O. es that the rigned by be detac	2		oo givoir iiri dici			obably 4 V Unknown
ords, v requit	Completed			24a. Was an autopsy		autopsy findings available ocompletion of cause of
tal Records rian: The law requ certificate has been ector, page 2 should	dmo			performe	ed? death?	
Vital R ysician: T his certific director, p	Be	overminer?	lace of Death (Check on			
of Vit ing Physic After this c	2	1 Yes 2 No Rospital 1 Inpatient 2 ER/Outpatient 3 DOA			esidence 6 🗸 Oth	er: Scene
Division of Vital Records, rate or Attending Physician: The law requirers after death at Director: After this certificate has been sted in by the funeral director, page 2 should the formers.	ion:	1 Natural 5 Deading (Month, Day, Year)	Ves 2 Tr No		w injury occurred	
Visic or Atte fter dea Director in by th	ficat	Accident  Accident  Suicide  Accident  Could not be  Suicide  Accident  Accident  Suicide  Accident  Accident  Suicide  Accident  Accide	ce building, etc. 2	unknown 8f. Location (Stre	eet and Number or F	Rural Route Number, City
Diversal of cours affilled i	Certification:	4 Homicide determined (Specify) Scene		Salisbury	, MD 202 Mout	nt Heron Road
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi-	Medical (	29a Certifier (Check only one) 2 Medical Examiner: On the best of my knowledge, death occurred at the time one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opin and manner stated.				
- × F ŏ	ğ	29b. Signature and title of certifier 29c. Lic	cense number		29d Date signed (M	
		Theretin U. FT JRune DI	.C.M.E.		October 24, 20	06
			Street, Baltimore,	MD 21201		
St Regist	ate rar	31. Date filed (Month, Day Year) CT 2 6 2006 September 19 19 19 19 19 19 19 19 19 19 19 19 19				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** 425 M Elvira 3 2006 ord 0 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner AAMC HUNDER 1 Year If Under 24 Hrs. AA 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** 1 M 2 30F Months Days Hours Director 215-34-9293 Germany Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ral", or Items 23a or 28a-f show Examiner must be notified at MI Arno 1 ☐ Yes ≱ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with 301 Alameda 21012 USA by Funeral 12. Was Decedent Ever in U.6. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify Specify: White 3 X Widowed 4 ☐ Divorced "natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry the Medical 16a. Decedent's Usual Occupation Give kind of work done during most of working life. DO NOT use retired) Anne Arundel County al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Public Schools Cafeteria Manager 12 alth and Mental Hygid 27 is marked other of traumatic event, the 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Franc Feser Anna Kolb 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 is any injury or other trau once. 510 horseshoe Trail Road, Denver, PA 17517 Frederick Ford/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State Oct. 18, 1 Burial 2 □ Cremation 3 □ Removal from State MD Veterans Cemetery Crownsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 2006 Barranco & Sons, P.A. Severna Park Funeral Home 21. Signature of Funeral Service Licensee 495 Gov. Ritchie Hwy, Severna Park, MD Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner The law requires that the death certificate be executed burial-transi resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical the attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 mont been signed by the atte Month Year 4☐Pregnant at time of death 9☐Unknown Day 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an certificate has b irector, page 2 s autopsy performed? 2 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes /2□ NO 2 ER/Outpatient 3 DOA Certification: To this 27. Mann of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 🔲 Yes 2 No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State

Registrar

30. Name and address of person

Year)

6

OCT

31. Date filed (Month, Day,

ho completed cause of death (Item 23a) (Type, Print)

32. gistrar's Signature

			For State Registrar		State of Ma	arylan	d / Depa <i>Cei</i>	artment of F rtificate of	lealth and Death	d Mental Hy	giene Reg. No.	2006	34582
			1. Decedent's Name (First,	Middle, Las	1)					2. Date of De	ath Day	Year	3. Time of Death
	Physici /Medic		Karen Mari	e Fi	sher					Octobe		, 2006	4:15 A. M
	Examin		4a. Facility Name (If not ins	titution, give	street and number)			4b. City, Town, o	or Location of De	eath	4c.	County of Death	
			11740 Asbury					Solomons				alvert	
	Funeral Director		5. Social Security Number 328–32–7572	6. Se	7. Ag		last birthday) Yrs.	If Under 1 Year Months Days	Hours M	lin. 8. Date of Bir (Month, Da July 1	th Year)	9. Birtho 939 Minn	place (State or Foreign esota
	pu &		Usual Residence of Deceded			10c Cib	y, Town or Lo	eation					IOd. Inside City Limits
	ehov ehov	7		,		_		Cation					1 ☐ Yes 2X No
	28a-f	Director	Maryland Ca.  10e. Street and Number	lvert		SOTO	omons	10f. Zip Code			10a Citi	zen of What Cour	
	a or					<b>!!4 04</b>	4						
	eath	era	11740 Asbur	y Circ	12. Was Deceden			20688	fisnanic Origin?	(Specify Yes or No		ted Stat	
30	n 72 hours after death with the Maryland "naturel", or iteme 23a or 28a-f ehow edical Examinat mual be notified at	by Funerai	1 Never Married 2	_	Armed Forces?  1 Yes 2 N If Yes, Give Year or Dates:	No.		f Yes, specify Cub 1 ☐ Yes 🛣 No	an, Mexican, Pu Specify:	(Specify Yes or No lerto Rican, etc.)	1	Black, White, Specify: Whi	etc.
5-0036	hour ture			cedent's Ed			16a Decer	deni's Usual Occup	ation			nd of Business/In	
Ċ	within 72 ene. than "nai	Completed	(Specify only	highest grad	de completed)		(Give	kind of work done DO NOT use retire	during most of	working		outer	dustry
7 7	d within	mo	Elementary/Secondary (0	0-12)	College (1-4or 5	)+)		istrative			Soft	tware De	velopment
0	at the	Be C	17. Father's Name (First, M	liddle, Last)					18. Mother's i	Name (First, Middle	, Maiden	Sumame)	
Maryland	d a b	To B	Paul Basil	Olinge	er				Ida Jı	ustine Ev	ers		
ā	ss 1 and 2 should by Health and Men Itam 27 is marker other traumatic.		19a. Informant's Name/Rei	lationship (7	ype, Print)		19b. Mailir	ng Address (Street	and Number or	Rural Route Numb	er, City o	r Town, State, Zip	Code)
	and 2 Baith a n 27 is		Tracy Parke	s (Dau	ighter)		2135	Tamarac	Trail,	Lusby, M	aryla	and 2065	7
<u>9</u>	tges 1 and of the or other		20a. Method of Disposition		2	20b. P	lace of Dispo	sition (Name of natory or other place	ce)	Date	20c. Lo	cation - City or To	own, State
Ĕ	Pages nent of int: if its iry or o		1 ☐ Burial 2 [XCrem 4 ☐ Donation 5 ☐ Ot							10/17/06	Alex	xandria,	Virginia
Baltimore,	permit. Page Department of Important: If eny injury or once.		21. Signature of Funeral S	ervice Licen	500			2. Name and Addre		Rausch F Road, Port I			
			23a. Part 1. Enter the disea	se, or comp	lications that caused	the death							Approximate
	Physician		shock, or heart failure Immediate Cause (Final	a. List only o			two at i	ro Dulmor	aaru Die	20350			Interval Between Onset and Death Years
	Physician /Medical	e e	disease or condition resulting in death)	-	aChronic			ve Pulmor	lary Dr.	sease			Tears
	Examiner					a 001100q1	donod ory.						
		Jer	Sequentially list conditions if any, leading to immediate	ė	b. — Due to (or as	a consequ	uence oi):						
	outed id ransit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	1	c								
o^	en ar rial-ti		resulting in death) Last		Due to (or as	a consequ	uence of):						
2/PC	icate be executed physicien and s the burial-transit	edicai			d								
0	- 0		IF FEMALE:								1		
XOD	death certific e attending p id for use as f	Physician/M	23b. Was decedent pregna	ATTE .	23c. If yes, outcome 1 ☐ Live birth	2 Fetal	death 3	Ectopic pregnancy	y		2	23d. Date of delive Month	ery Day Year
o o	0 0 0	/slc	in the past 12 months 1 ☐ Yes 2 No 9 ☐ Unknown		4□Pregnant at 9□Unknown	time of de	eath 5	Other (specify) _				WOTTE	Day Tou.
7.	hat the		Part II. Dther significant co	onditions co	entobuting to death b	ut not resi	ulting in the u	nderlying cause giv	ren in Part I	23e Did t	obacco u	se contabute to the	he cause of death?
ecords,	w requires that the been signed by th should be detache	ted by				ut 1101 1001			on art art art art art art art art art art				pably 4 Unknown
ပ္ထ	aw 2 s b	Completed								24a. Was		24b. Were auto	psy findings available mpletion of cause of
ľ	Th ate pag	NO.								perfo	rmed?	death?	2 No
Ital	Physician: T this certificat ral director, pa	Be (	25. Was case referred to mexaminer?	nedical					26. Place of I	Death (Check only	one)	-	
0	Physic this c	ို	1 ☐ Yes 2X No		Hospital: 1 🗌 Inpatie	_	ER/Oulpatier		4 🗆 14015111	g Home 🔥 Resi	dence 6	Other (Specif	(y)
	ding P h. After funera	inol.		Pending	28a. Date of Inju (Month, Da)	ry y Year)	28b. Time of Injury	Wor		28d. Describe	how injur	y occurred	
S	Attending r death. sctor: After by the fune	cat	2 - 100100111	nvestigation Could not be					Yes 2 No				
DIVISION	in Direct	Certification:	4 Homicide	determined	28e. Place of Inju- building, et	ury - At ho c. <i>(Specif</i> )	ome, farm, str y)	eet, factory, office		28f. Location ( City or To	Street and wn, State,	d Number or Rura )	al Houle Number,
	e Hoepital 24 hours a E Funeral letely filled	Medical (	29a. Certifier X Ce	ertifying Phy edical Exam	/sician: To the best iner: On the basis of and manner sta	examina	wledge, death tion and/or in	n occurred at the tirvestigation, in my o	me, date and pla pinion, death o	ace, and due to the ccurred at the time,	cause(s) date and	and manner as s place, and due to	tated. the cause(s)
	To the within 2. To the Complet	Me	29b. Signature and title of	certifier				29c. Licens	se number		29d. Date	e signed (Month,	Day, Year)
			DITT.	, M	h			D403	70		0cto	ber 17,	2006
	19244		30. Name and address of p	erson who	completed cause of d	eath (Item	23a) (Type,		. •				
	ID		Peter Wisni	ewski	MD 10845	Tow	n Cent	er Blvd.	, Suite	204, Dun	kirk	, Maryla	nd 20754
	Sta		31. Date filed (Month, Day,	Year)	32. Registr	Signa	ture	- 8 . 40 .	9				
200	Registi	ar	(	JUI1	8 2006	WALLA	ce St.	STORAGE!	7				

			For State Registrar	State of Maryla		ertificate of F			ene 006	34583
H	Physicia		1. Decedent's Name (First, Middle, Las			<del></del>		2. Date of Death Month	Day Year	3. Time of Death
	/Medic	al	Warren Gregory			41 O'r T	- L size of Dooth	Octobe	r 18 200	
	Examin	er	4a. Facility Name (If not institution, give Washington County			Hagers	r Location of Death		4c. County of Dear	
	Funeral		5. Social Security Number 6. Se	7. Age (In y	rs. last birthday			8. Date of Birth (Month, Day, )		thplace (State or Foreign
	Director		091-14-9004 1/2 Usual Residence of Decedent	ØM 2□F 82	Yrs.	Says		April 9,	1924 Pen	nsylvania
	yland now	Ì	10a. State 10b. County	10c.	City, Town or I	_ocation				10d. Inside City Limits
	Ba-f et	ctor	Maryland Washing	ton W	illiams	port				1X Yes 2 □ No
	with th	Director	10e. Street and Number			10f. Zip Code			g. Citizen of What Co	ountry?
	ns 23	Funeral	13 East Frederick	12. Was Decedent Ever in	n U.S. 13	. Was Decedent of I If Yes, specify Cub	Hispanic Origin? (Sp		USA 14. Race - Ame	
50	4 within 72 hours after death with the Maryland Jien. Then "natural", or Items 23e or 28e-f ehow the Madical Examinar must be notified at	by Fur	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	Armed Forces? 1 XYes 2 No 1 If Yes, Give Year or Dates: 19	942 <b>-</b> 944	If Yes, specify Cub 1 ☐ Yes 2 ☑ No		Rican, etc.)	Specify:	e, etc. n i †e
2-0030	72 hou natura ical E	ted	15. Decedent's Ed (Specify only highest gra	ucation	16a. Dec	edent's Usual Occup e kind of work done	pation	ing 16	5b. Kind of Business	
Ž	nithin 7	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retire	d)			C!-
7	Hygie Hygie Ither ti	e Co	12 17. Father's Name (First, Middle, Last)		Mach	ine assem	T	e (First, Middle, Ma	andblasti	ng Equip.
land	Aental rked c	To B	Meigs A. Fish, Jr	•			Rose C.	Mirolli		
lary	and h		19a. Informant's Name/Relationship (7	Type, Print)	19b. Ma	ling Address (Street	and Number or Rui	al Route Number,	City or Town, State,	Zip Code)
e, S	s 1 and of Heelth Item 27 other tr		Teresa M. Fish - I			Apple Wa			17252 Dc. Location - City or	Town State
Ď	2°= 5		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Hemovai from State		position (Name of ematory or other pla				t,Maryland
Baitil	글투란글 .		21. Signature of Funeral Service Li	1111					eral Home	
ñ	Depe Impo eny i		( rught	El		425 S.Co	nococheag	ue St. W	illiamspo	rt,MD 21795
		3 1	23a. Part1. Enter the disease, or comp. shock, or heart failure. List only	one cause on each line.			-	or respiratory arres	st,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as a con		RY PAIL	-4RE			
	Examiner			b CEREBR		ME AC	CIDONT			
	p #	ner	Sequentially list conditions, any leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a con	saquence of):					
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28/60	ificate be executed g physicien and as the burial-transit	cal				FNM F		3-		
_	CD es	P	IF FEMALE:							
X Q Q	death certifi e attending I id for use as	clan/M	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pre 1 Live birth 2 F 4 Pregnant at time	etal death 3	Ectopic pregnand	у		23d. Date of de Month	livery Day Year
j.	the de	Physic	1 Yes 2 No 9 Unknown	9□ Unknown	ordeam s	Other (specify) _				
λ, J	w requires thet the de been signed by the should be detached	by PI	Part II. Other significant conditions of	-	resulting in the	underlying cause gr	ven in Part I.			the cause of death?
ord	requir een si hould	sted	COAGULO					1 🗆 Yes	2 □ No 3 □ P	robably 4 @Unknown
Vital Records,	e la hes je 2	Completed	RATIONO	MYOLYSI	ς			24a. Was an autopsy perform	ed? prior to death?	utopsy findings available completion of cause of
<u>ra</u>		0	25. Was case referred to medical				26. Place of Deal	1 ☐ Yes 21 h <i>Check only one</i>	ENo 1 ∐ Yes	3 2 □ No
5	Q Q	To B	examiner? 1 Yes 2 No		2 ER/Outpati	ent 3□ DOA Ot			ce 6 □Other (Spe	ocify)
	ding Ph h. After th tuneral	Certification:	27. Manner of Death  1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Yea	r) 28b. Time Injury	Wo	nyat ⊮k? ]Yes 2 ∐No	28d. Describe how	v injury occurred	
UIVISION	Attending r death.	ifica	2 Accident Investigation 3 Suicide 5 Could not be 4 Homicide determined	28e. Place of Injury	At home, farm,		,	28f. Location (Stre	et and Number or R	ural Route Number,
בֿ	rs elter	Cert	/	building, etc. (Sp				City or Tówn,		
	To the Hoepital or Within 24 hours elte To the Funerel Dir completely titled in	edical	29a. Certifier 1 Certifying Ph (Check only 2 Medical Examone)	ysician: To the best of my niner: On the basis of exam and manner stated.	knowledge, de nination and/or	ath occurred at the ti investigation, in my	me, date and place, opinion, death occur	and due to the cau red at the time, dat	use(s) and manner as e and place, and due	s stated. e to the cause(s)
	Within To the compl	Me	29b. Signature and title of certifier			29c. Licen	se number	29	d. Date signed (Moni	
- 6	<b>D</b> .		Agral				62006		10/18/0	Ь
	, 10 K/		30. Name an ress fp rson who DAU 10 AUY AUG -			_ *	- /T	· Cone	== 444	6 000 114 1 141 A
	Sta	te	DAVID ANT MAG- 31. Date filed (Morph Pay, Year) 20	32. Jogistrar's S	ignature -	CAST A	NIEFAN	n sma	TATLES	ESTOUR MD
	Registr		001 20 20	100 Been	1. B.	celes				

			1 - For State Registrar		State of Ma	arylan	-		nt of Ho te of E		nd Me		iene	006		34584
	Physici			e (First, Middle, Last) ra Jean Fo			-:					2. Date of Death Month	- 0	Year O 6		3. Time of Death
)	/Medio Examir		4a. Facility Name (I	If not institution, give :	street and number)	Por	rf11	4b. City	Town, or	Location of	Death	,	7	Junty of De	ath	
	Funeral Director		5. Social Security N 214-42-	4637 10		63	ast birthday) Yrs.	If Unde Months	Days	If Under 2 Hours	Min.	8. Date of Birth (Month, Day, 06/08/19		9. Bi	thpla- cuntry	ce (State or Foreign
	ryland		Usual Residence of 10a. State	10b. County		10c. City	, Town or Lo	ocation							100	I. Inside City Limits
	he Ma 26a-f	Director	DE	Sussex		L	Delm								1_	1 ☐ Yes 2√ No
	With t	Dir	10e. Street and Nur 15054	mber 4 Whitesvi	11e Road			10f. Z	p Code 1994	40		10	og. Citize	n of What C		y?
36	72 hours after death with the Maryland natural', or items 23a or 28a-f ehow dical Examinar must be rodified at	by Funerai	11. Marital Status	ied 2□ Marned	12. Was Decedent Armed Forces? 1 ☐ Yes 2 ☑ I If Yes, Give			Was Dece If Yes, spe 1  Yes	edent of His ecify Cubar		in? (Spec Puerto P	offy Yes or No- lican, etc.)		USA Race - Am Black, Wh	ericar	C.
Maryland 21215-0036	s 1 and 2 should be filed within 72 hours after death with the Marylan f Heelth and Mental Hyglene. Item 27 is marked other then "natural", or items 23a or 28a-f ehow other treumatic event, Ira Medical Examinar must be notified as	Completed b		15. Decedent's Edu cify only highest grad	College (1-4or 5	5+)	life.	kind of w DO NOT	ork done d use retired)	u <i>ring</i> most		g		of Busines:		stry
d 2	Hygie Hygie other t		17. Father's Name	(First, Middle, Last)	3		Su	bst1	tute	Teach		(First, Middle, M			311	
lan	Aental Aental rked c	To Be	Russell	Irwin Smi	th							rinne K				
Many	12 should be filled within n and Mental Hygiene. Fis marked other then " reumatic event, the Me			ame/Relationship (Ty						nd Number	or Rural	Route Number,	City or T		Zip C	ode)
	ges 1 and 2 tof Heelth ff item 27 or other trees.		20a. Method of Dis	. Darst/ D	augnter	20b. P	lace of Dispo	sition (Na	me of			y, Kent		40( tion - City o		State
mor			1 🔀 Burial 2	☐ Cremation 3 ☐ F	emoval from State	C	emetery, crei Johnst	natory or	other place			8/2006		•		
Baltimore,	permit. Pege Depertment of important: if eny injury or once.		21. Signature of Fu	uneral Service Licens	9e		22	2. Name a	nd Address	s of Facility	1	3 E. Gro elmar, 1	2770	troot		) <u>E</u>
			23a. Part1. Enter t shock, or hea	the disease, or compl in failure. List only or	cations that caused the cause on each li	d the death	n. Do not ent	er the mo	de of dying	, such as c	ardiac or	respiratory arre	est,	7740	A	pproximate nterval Between
	Physician		Immediate Cause disease or condition resulting in death)	(Final	dir	Mos	15									Inset and Death
	/Medical Examiner		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	(	Due to (or as	a consequ	uence of):									
	ecuted and -transit	Examiner	Sequentially list co if any, leading to in cause. Enter Undo Cause (Disease or that initiated events resulting in death)	injury s	Due to (or as											
68760,	ificate be executed physicien and as the burial-transit	edical E			J	a consequ	Jence 01).			·					-	
O. Box	The law requires that the death certific ate hes been signed by the ettending F cage 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was deceden in the past 12 1 Yes 2 9 Unknown	months?	3c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal	death 3	Ectopic p					230	I. Date of de Month		ay Year
rds, P	quires that on signed b uld be deta	۵	Part II. Other signit	sing escap	1	ut not resu	ulting in the u	nderlying	cause give	n in Part I.			acco use			cause of death?
of Vital Records,	The law requirate hes been spage 2 should	Completed	perit	onitis	10/ 8	5						24a. Was ar autopsy perform	/	24b. Were a prior to death?	como	y findings available pletion of cause of
ital		0	25. Was case refer	reguto medical	qual yacı	24				26. Place	of Death	1 Yes 2	ØNo _	1 🗆 Ye	s 2	□ No
of V	× ~ 5	To B	examiner?	140	lospital: 1 Hinpatie		ER/Outpatier			r: 4 🗆 Nur		e 5 🗆 Reside	0.01	]Other (Sp	ecify)	
	ding Ph h. After th funeral	tlon:	27. Manner of Deal	5 Pending	28a. Date of Inju (Month, Da	y Year)	28b. Time o Injury	f M	28c. Injury Work	at ? es 2 ☐ N		8d. Describe ho	w injury o	ccurred		
Division	l or Attendi efter death. Director: A in by the fu	Certification;	2 Accident 3 Suicide 4 Homicide	investigation 6  Could not be determined	28e. Place of Inj building, et	ury - At ho c. (Specify	ome, farm, str					8f. Location (Str City or Town	eet and N State)	lum <i>b</i> er or F	Rural F	Route Number,
-	To the Hospital or Attending within 24 hours efter death.  To the Funerel Director: After completely filled in by the funer	edicai C	29a. Certifier (Check only one)	1 Certifying Phys	ner: On the basis of and manner sta	f examinal	wledga, deat tion and/or in	Security vestigation	at the time, in my op	a date and inion, death	l Jaco, a h occurre	nd due to the ea d at the time, da	uce(s) an ite and pl	d manner a ace, and du	s stat e to th	ed. ne cause(s)
	To th within To th	Me	29b. Signature and	telegol centrior	1				c. License			29	d. Date s	igned (Mon	th, Da	y, Year)
	40			Hend				/	HOOS	936	8		10/1	3/06	>	
	IMP		30. Name and ag	ress of person who co	mpleted cause of d	eath (Item	23a) (Type,	Print)	alish	ury,	MD	21804	ž_			
7	Sta Registi		31. Date filed (Mon		32. <b>P</b> egistr	ar's Signa	ture	perki	,							

Barbara S. Fowler 214-43-4637

			For State Registrar	State of Ma	aryland	d / Departr	ment of	Health and I Death			2006	34585	
	Physicia /Medic		1. Decedent's Name (First, Middle, Nelson James	Last) Frazier					2. Date o Month	D	ay Year	3. Time of Death  OH57 M	
	Examin		4a. Facility Name (If not institution, Memorial Hos 5. Social Security Number	Pital at		ast birthday) If	Under 1 Yea			f Birth	c. County of Deal	hplace (State or Foreign	
	Director		218-24-7288 Usual Residence of Decedent	1 <b>∑</b> M 2□F	76	Yrs.	Ontins Day:	S Hours Will.		/1929		yland	_
	the Maryland	tor	MD 10b. County Caroli	ne	,	r, Town or Location	on					10d. Inside City Limits 1 ☐ Yes 2 No	
	with the a or 28a	Funeral Director	10e. Street and Number			1	Of. Zip Code			10g. C	itizen of What Co	ountry?	
-	eath v	erai	16840 Henderson	Road Lot 11		S 13 Was	2164		pecify Yes o	r No-	U.S.A.	nican Indian	_
) (	within 72 hours after death within 72 hours after death then "naturel", or Items 23 the Medical Examination missi	Ď	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces?	10		s, specify Cu Yes 27 No	Hispanic Origin? (Saban, Mexican, Puerto Specify:	to Rican, etc.	)	Black, Whit		
W Nelson Maryland 21215-0036	hin 72 ho n "natur Medical	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	Education		16a. Decedent (Give kind life. DO f	s Usual Occi of work don VOT use retir	upation e during most of wor red)	rking	16b.	Kind of Business	Industry	
3	filed with Hygiene other the	Com	11		,	<u>lab te</u>	chnici				ood indu	stry	
Ned and 21	s 1 and 2 should be filed with t Health and Mental Hygiene item 27 le marked other than other traumatic event, ITEM	Be	17. Father's Name (First, Middle, L.					18. Mother's Nar			n Sumame)		
<u>( - 2</u>	2 should be and Mental le marked o aumatic eve	ပ္	Bernard Frazi			19b. Mailing A	ddress (Stree	Mamie et and Number or Ru			or Town, State, 2	Zip Code)	_
			Everett W. Frazi			-		Drive; U					
Fraz.	of Hei		20a. Method of Disposition 1 ▼Burial 2 □ Cremation	□ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □	20b. PI	lace of Dispositio emetery, cremato	n (Name of ny or other pi	lace)	Date	20c. l	Location - City or	Town, State	
	nit. Pages partment of cortent: If it Injury or o		4 Donation 5 Other (Spe	ocify)	Gree	ensboro					eensboro		
上電	Departiment Importing Indiana		21. Signature of Funeral Service Li	Kly		1		ress of Facility $106$				Box 160 fenbein FH	
8760.		lical Examiner	shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any learning transparent cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a d. d.	MON a consequ	rence of):						Interval Between Onset and Death	
P.O. Box 68	Attending Physicien: The law requires that the death certifical releast.  setter: Aller this certificate hes been signed by the attending phy the funeral director, page 2 should be detached for use as the	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. tf yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal	death 3 ☐Ect	opic pregnan ner (specify)			_	23d. Date of del Month	ivery Day Year	
d Sp	uires that n signed b		Part II. Other significant condition	s contributing to death bu	ut not resu	Ilting in the under	tying cause g	given in Part I.		Oid tobacco		the cause of death?	
Division of Vital Records.	sicien: The law requir certificete hes been si irector, page 2 should	Completed							a	Vas an lutopsy performed? es 2 N	prior to death?	itopsy findings available completion of cause of 2 Mo	
Z.	sicler certif irector	o Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☑ No	Hospital:	001		7.00.	26. Place of Dea			- Cau 10		_
ion of	nding Phys ath. r; After this e funeral di	ation: To	27. Manner of Death  1 Matural 5 Pending 2 Accident investiga	28a. Date of Injur (Month, Day		28b. Time of Injury	28c. Inj W M 1[				6 ☐Other (Speurred	city)	_
Divis	: 5 g g :=	Certification:	3 Suicide 6 Could no 4 Homicide determin		ury - At ho c. (Specify	me, farm, street,	factory, office	9	28f. Location City or	on (Street a Town, Sta	and Number or Ru te)	ural Route Number,	
	Mospital 24 hours a Funerel l etely filled	edicai	29a. Certifier 1 Certifying (Check only one) 2 Medical E	Physicien: To the best of caminer: On the basis of and manner sta	examinat	wledge, death occion and/or investi	curred at the igation, in my	time, date and place opinion, death occu	, and due to irred at the ti	the cause( me, date a	s) and manner as nd place, and due	stated. to the cause(s)	
	To the within 2 To the comple	Me	29b. Signature and title of certifier					nse number		29d. D	ate signed (Mont	h, Day, Year)	-
			> foliats	otsu			20	05948	7		10/17/0	6	
			30. Name and address of person w	ho completed cause of de	eath (Item	23a) (Type, Prin	t)						Ī
			John Botsis, MD 31. Date filed (Month, Day, Year)	219 S. Wa	shing	ton St.	; East	on, MD 21	601				_
	Sta Registr		GCT 1 9 200	6 Carre	. Di	Anarle !	F						

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 2006 10:10 PM Beth Ford Kaelce LO /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner University of Maryland Medical Center Baltimore Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 6. Sex 5. Social Security Number Days Hours **Funeral** 1 M 2 F 10/12/2006 Maryland nla Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County itsm 27 is marked other than "naturel", or iteme 23e or 28e-f show other treumstic event, the Medical Examiner must be inclined at 1 Yes 2 No nla na Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number nla United na 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Black, White, etc. 11 Marital Status 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: White Specify ۵ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Cotlege (1-4or 5+) and Mentel Hygiene. Elementary/Secondary (0-12) nla nla na Depermit. Pages 1 and 2 should be file.
Department of Heelth and Mentel Primportent: If Item 27 Is month injury or other. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Marie tora Jeremy 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Na. e/Relationship (Type, Print) Delmar  $\mathcal{D}r$ . Md. 21875 Ford tather 8195 Lynch Jeremy 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place) 10/18/2006 1 Burial 2 ☐ Cremation 3 ☐ Removal from State odd Fellows Cemetery Laurel, 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Framptom Funeral Home, PA Federal Sburg, Md. 21632 21. Signature of Funeral Service Licensee Pristine 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pneumothorax onehour **Physician** /Medical Due to (or as a consequence of) Examiner Pulmonary hemorrhage Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Distress Syndrome attending physicien and for use es the buriel-transit The law requires thet the death certificate be executed Kespiratory Due to (or as a consequence ot): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. F been signed by the a should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ۵ 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No Completed growth restriction 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has t irector, page 2 s autopsy performed? Patent Ductus Artenosus 1 ☐ Yes 2 ☐ No 1 Yes or Attending Physicien: 25. Was case referred to medical examiner? director, 26. Place of Death | Check only one Be Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes ≥ No Certification; To 2 ER/Outpatient 3 DOA this 27. Manner of Death After thi 28b. Time of Injury 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Yes 2 No within 24 hours eftar death.

To the Funeral Director: A complately filled in by the fu 2 Accident 6 Could not be determined 3 ☐ Suicide 28t. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of tnjury - At home, tarm, street, tactory, office building, etc. (Specify) 4 Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D3357 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) South Greene Street Baltimore Maryland 21201 Day, Year) 32. Registrar's Signature 31. Date filed (Month. State Registrar

DHMH 17 Rev 1/2001

			1 - For State Registrar	State of I	Marylan	-	artment rtificate			and M	-	giene	) 6	34588
	Physici		1. Decedent's Name (First, Middle   HAPLES	e. Lasti	240/2		-				2. Date of De Month Octobe	Day	Year 2006	3. Time of Death 6:22 a M
	/Medic Examin	_	4a. Facility Name (If not institution				4b. City,	Town, or	Location o	f Death	OCCODE		y of Death	0:22 a
			KRIS /	eiGH				bril				Anne	e Arui	nde1
	Funeral Director		5. Social Security Number 234-20-8678		Age (In yrs 81	last birthday) Yrs.	If Under Months	1 Year Days	If Under 2 Hours	Min.	8. Date of Bird (Month, Da July 19	v. Year)	9. Birthp Coun West	lace (State or Foreign try) Virginia
W	D		Usual Residence of Decedent  10a. State 10b. County		100 Cit	y, Town or Lo	antion.							
	Aaryla f shov	5		Arunde1		Crowns								0d. Inside City Limits 1 ☐ Yes 2√ No
	28a-	Director	10e. Street and Number	TIT GIRGE		OLOWID	10f. Zip	Code				10g. Citizen of	What Coun	try?
	th with	aiD	1008 Tudor Dri	ve				2103	2			USA		
36	be filed within 72 hours after death with the Maryland stal Hygiene. ed other then "natural", or Iteme 23a or 28a-f show event, the Medical Examinar must be restlind at	by Funerai	11. Marital Status  1 □ Never Married 2 □ Mar	If Yes Give	ss? □ No		Was Deced If Yes, spec 1 ☐ Yes 2	rfy Cubai	spanic Orig n, Mexican Specify:	gin? (Spe , Puerto F	cify Yes or No Rican, etc.)		ce - Americ ack, White, ify: Wh	
2-0	72 hou			nt's Education st grade completed)		16a. Dece	dent's Usua kind of wor	I Occupa	ation	of workir	20	16b. Kind of E	Business/Ind	dustry
21215-0036	within ene.	Completed	Elementary/Secondary (0-12)	College (1-4	or 5+)	life.	DO NOT us	se retired,	)		.9	Federa	1 Corr	rnmont
5 0	e filed within al Hygiene. I other then vent, the Me	e Co	17. Father's Name (First, Middle,	Last)		Consu	Tring	Elig		_	(First, Middle,	Maiden Suma		er mment.
<u>lan</u>	should be nd Mental marked o	To B	Charles E. Gre	ene					Eve	1yn	Moyer			
Maryland	2 sh and ls m		19a. Informant's Name/Relations				_					er, City or Town		Code)
	s 1 and if Heelth Item 27 other tr		Robert Greene 20a. Method of Disposition	(Son)	20b. F	Place of Dispo semetery, crei					nsville ate	20c. Location		wn, State
OE	Pages ent of nt: # li ry or c		XXBurial 2 Cremation 4 Donation 5 Other (5		110	ryland				10-1	3-2006	Crowns	ville.	, MD
Baltimore,	permit. Pages 'Department of H Important: if Ite any Injury or ot		21. Signature of Funeral Services	Licensee		100	Name and	d Addres	s of Facility Fune	ral	Home, I			
8760,	Physician /Medical Examiner  physicien and physicien and physicien and physicien and physicien are physician at the physician are physician at the physician at	lical Examiner	23a. Part1. Enter the disease, o shock, or heart failure. Lis Immediate Cause (Final disease or condition resulting in death)  Sacual they list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that inditated events resulting in death) Last	a. Due to (or b. Due to (or c.		vasc uence of):						rrest,		Approximate Interval Between Onset and Death  Mownes
P.O. Box 6	death certific e attending p id for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		n 2 ∏Feta ntattime of d	Ideath 3	□Ectopic pro□Other (sp				Ta - 1.50 to		ate of delive	ory Day Year
	Se 50 9	by P	Part II. Other significant condition			ulting in the u	inderlying ca	ause give	en in Part I.		23e. Did t	obacco use cor	ntribute to th	ne cause of death?
ord	w requir been si should		ATRIAL FIL		on						1 🗆 '	Yes 2□No		ably 4 □Unknown
al Records,	The ete h page	Completed	HYPERTER								24a. Was autoj perfo 1 Yes	an 24b. osy ormed?	prior to cor death?	psy findings available inpletion of cause of
Vital	Physicien: this certifice ral director, p	o Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☐ No	Hospital:	atient 2	ER/Outpatie	ot 3 🗆 DO	Othe	200		ne 5 ☐ Resi		than (Casa)	ME
ion of	ding h. After fune	atlon: To	27. Mann → 1 Death 1 Natural 5 ☐ Pendi	28a. Date of		28b. Time o Injury		8c. Injury Work		2		how injury occu	ther (Specify urred	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
Division	P et c	Certification:	3 Suicide 6 Could 4 Homicide deter	ningd 200. Flace of	Injury - At h , etc. <i>(Specii</i>	ome, farm, st	reet, factory	, office		1	28f. Location ( City or To		nber or Rura	l Route Number,
	To the Hospital or within 24 hours effe To the Funeral Dir completely filled in	Medicai	29a. Certifier 1 Certifyi (Check only one) 1 Medica	ng Physician: To the b I Examiner: On the bas and manne	is of examina	ation and/or in	vestigation,	, in <i>m</i> y or	pinion, dea	th occurr	ed at the time,	date and place	, and due to	the cause(s)
	To the vithin 2 Complete	Me	29b. Signature and title of certific	ig ?	7		290	License De	o number 463	60		Ola	ted (Month.	Day, Year) P, 2006 Puil M
	Troet		30. Name and address of person	who completed cause	of death (Iter	n 23a) (Typa	Print)	Vor	004=	c H	C. His. A.	Mil	OPCIL	Mell
	St Regist	ate rar	31. Date filed (Month, Day	1 6 2006 Res	gistras Signa	ature &	Aba	all s	WIN.	3116	UNWIT)	17/100	- 1-30	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** () C /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Medical Center Anne Arundel Annapolis 6. Sex 1 M 2 □ F 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, July 2 Birthplace (State or Foreign Country) **Funeral** 1944 Months Days Hours Min. 62 171-36-6594 July | Director Pennsylvania Usual Residence of Decedent 10a. State 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene.

Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10d. Inside City Limits Director 1 ☐ Yes 2☐ No MD Anne Arundel Crofton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1900 Pawlet Drive 21114 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 Never Married XX Married ☐ Yes **②**No Yes, Give Saltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo White Specify. ģ 3 Widowed 4 Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Accountant Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joseph Gatto Rose Pignatelli ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lorraine Gatto (Wife) 1900 Pawlet Drive, Crofton, MD 21114 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Our Lady of the Fields 10-16-2006 Millersville, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
Hardesty Funeral Home, P.A. 851 Annapolis Road, Gambrills, MD 21054 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death ELY Immediate Cause (Final WID METASTATIC Physician BLADDEN disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence or, Examiner law requires that the death certificate be executed burial-transi Due to (or as a consequence of): Box 68760. attending physician Physician/Medical use as the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy for in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.0. been signed by the a should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform certificate 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA မ this 27. Manner of Death 28a. Date of Injury 28b. Time of After t 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After Certification: 5 Pending investigation (Month, Day Year) Injury 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only

State

Registrar DHMH 17 Rev 1/2001 29b. Signature and title of certifier

31. Date filed (Month, Day,

Year)

30. Name and address of person who completed cause of death (Item 232) (Type, Print) 32. Regis

29c. License number

47 GHWAY ANNADUS M 221401

Amended Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Item #26. For WCHD/10-19-06 State of Maryland / Department of Health and Mental Hygiene 005 34590 State Registrar SC Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** Carroll Maynard HAYNES October 18, 2006 12:02 a.™ /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** Julia Manor Nursing Home Hagerstown Washington 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Sept. 5,1915 **Funeral** 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) Months Days Hours Min. 1⊠M 2□F Yrs. 214-09-3713 Director Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 X No Director Maryland Washington Hagerstown 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 118 N. Colonial Drive 21742 USA or Items 23s Funera 12. Was Decedent Ever in U.S. Armed Forces? 1 ★ Yes 2 □ No If Yes, Give Year or Dates: ₩₩ II Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11 Marital Status 72 hours after 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: white þ 3 ☐ Widowed 4 ☐ Divorced natural Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) filed within 7 Hygiene. other than "r Elementary/Secondary (0-12) College (1-4or 5+) banker banking 12 is 1 and 2 should be filed voil Health and Mental Hygie item 27 is marked other I 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be David Harold Haynes Elsie Catherine Haines 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17828 Burnside Ave., Hagerstown, Maryland 21740 Philip R. Haynes - son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages
Department of Inportant: If its
any injury or of 1 

Burial 2 □ Cremation 3 □ Removal from State Locust Grove Cem. 10/22/06 `4 □ Donation 5 □ Other (Specify) Rohrersville, Maryland MINNICH FUNERAL HOME 21. Signature of Funeral Service License 15 E. Wilson Blvd., Hagerstown, Md. 21740 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician (ongestine 10 resulting in death) /Medical Due to (or as a consequence of): Examiner MASHIZ if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner certificate be executed burial-transit Due to (or as a consequence of): physician Box 68760 Physician/Medical the th IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 Other (specify) P.O. the detached à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an 1 ☐ Yes 2 No the Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 ursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: After 5 Pending investigation 1 Salatural death. 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) after 4 Homicide within 24 hours a Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2 10-13-6 200 WASEEN 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hagerst 26 0 10 0

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

19 2006

82. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day **Physician** Month Year October 8, Ella Marie Horner 2006 3:20 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Dorchester General Hospital Cambridge Dorchester If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1□M 2/□F Yrs. Director 214-07-7297 93 May 13, 1913 Maryland Usual Residence of Decedent within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits rthen "naturel", or Iteme 23a or 28a-f ehov It e Medical Exerticer must be notified at Maryland Dorchester No 2 No Director Cambridge 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 520 Glenburn Avenue 21613 US 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2XXVo Specify: Specify: White Completed by XXWidowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17 Father's Name (First Middle Last) 18 Mother's Name (First Middle Maiden Sumame) 2 should be fi and Mental H is marked of Be John Tall Laurena Aaron 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 end 2 to Department of Heelth ar Important: If Item 27 is eny injury or other treu Stephen E. Horner, Sr. Son 6538 Cabin Ridge Road Hurlock, Maryland 21643 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Dor. Memorial Park 10/13/06 Cambridge, Maryland 21. Signatury Funeral Service Licensee 22. Name and Address of Facility Thomas Funeral Home, P.A. 700 Locust Street Cambridge, Maryland 21613 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Se **Physician** OSis /Medical Due to (or as a consequence of): Examiner Uricara tract Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Quality for as a consequence of) physiclen and the burial-transit The law requires thet the death certificate be executed Muo cordiz1 Due to (or as a consequence of) P.O. Box 68760. by Physician/Medical IF FEMALE: esn esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 2 Fetal death in the past 12 months?
1 Yes 2 No è Month Day 4□Pregnant at time of death 5 Other (specify) signed by the a d be deteched f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. 2₽No 3 Probably 4 Unknown 1 TYes Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform page 1 Yes 2 No 1□ Yes 2⊡No 25. Was case referred to medical funeral director 26. Place of Death | Check only one examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Certification: Hospital or Attending 1 Matural 5 Pending Injury setter deeth.

Director: Aff
in by the fur 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide within 24 hours er To the Funerel C completely filled i 29a. Certifier 1 Certifying Physician: To the best of my knowledge death occurred at the time data and plans, and due to the causa(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D47924 10-12-06 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CAMBRID CE 300 AURURA NOMAIN MD 21613 2006 32. Registrar's Signature 31. Date filed (Month, State Registrar

State of Maryland / Department of Health and Mental Hygiene. Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** Alfred C. Kulp October 11, 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harrison Senior Living Center Worcester Snow Hill If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1**X** M 2□ F Yrs. 86 Director 201-07-1176 11/10/1919 Maryland Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. tnside City Limits r then "netural", or iteme 23a or 28a-f ehow the Medical Examinar must be notified at 1 Yes 2 No Director Maryland Worcester Snow Hill 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 430 West Market Street 21863 USA 12. Was Decedent Ever in U.S.
Armed Forces?

1X☐ Yes 2 ☐ No Army
If Yes, Give
Year or Dates: WW II Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: white þ 3X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Peges 1 and 2 should be filed within 72.
Depertment of Heelth and Mental Hygiene.
Important: If item 27 is marked other then "ne any injury or other treumatic event, Ite Mazila once. Elementary/Secondary (0-12) College (1-4or 5+) Mechanical Technician National Cash Register 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Alfred Kulp Theresa Welch 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Patricia Voigt/daughter 132 Milestone Rd., Elkton, MD 21921 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State cemetery, crematory or other place Wicomico Memorial Park 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 10/17/06 Salisbury, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Lice see 25611 WAY FUNETAL Howe Professional Association Korth 23a. Part1. Enter the disease, or complicate his that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intervat Between Onset and Deat fmmediate Cause (Final disease or condition resulting in death) Malignant **Physician** /Medical Due to (or asa consequence of) Examiner Sequentially list conditions, if any, feating to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine ete hes been signed by the attending physiclen and page 2 should be detached for use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 3 Probably 4 □Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 2 1 No 1 Yes 2 No 1 Yes i or Attending Physicien: after death. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☐ No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 DNatural 28b. Time of Injury 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 5 Pending 1 Tes 2 No investigation 2 Accident Director: 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. City or Town, State) 4 | Homicide To the Hospital or within 24 hours aft 1 Cartifying Physician: To the best of my knowledge death occurred at the time, data and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier (Check only one) 29b. Signature and title of certify 29d. Date signed (Month, Day, Year) D0054422 Sarad 30. Name and address of person who completed cause of death (Item 2 le) (Type, Print) aral St. 10 como Ke May 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

**ORIGINAL** 

DHMH 17 Rev 1/2001

Registrar

1 6 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 34593 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) October 14, 2006 9:18A Lord 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Montgomery 9 Laurel Leaf Ct. Potomac If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Yea 6-19-1919 9. Birthplace (State or Foreign Country) New York 5. Social Security Number 7. Age (In yrs. last birthday) 1 ☐ M 2 🖾 F 87 060-16-0092 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County MD Potomac 1 ▼ Yes 2 No Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20854 U.S.A. 9 Laurel Leaf Ct. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 No 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Social Worker White

12th 17. Father's Name (First, Middle, Last)

Hyman Gordon

18. Mother's Name (First, Middle, Maiden Sumame)

Bertha Gordon

19a. Informant's Name/Relationship (Type, Print) Patricia Lord Miller- Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
9 Laurel Leaf Ct. Potomac, MD 20854

10-16-06

Date

20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐Removal from State 4 ☐ Donation 5. ☐ Other (Specify) 21. Signature of Fune al Service Licensee

22. Name and Address of Facilit Edward Sagel Funeral Direction

and mo 1091 Rockville Pike Rockville, MD 20852 Approximate Intervat Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

20b. Place of Disposition (Name of cemetery, crematory or other place)

New Montefiore

**Physician** /Medical Examiner

attending physician and for use as the burial-transit

detached

certificate has been signed by rector, page 2 should be detac

funeral director.

the

filled in by

completely

After t

after death.

within 24 hours a To the Funeral C

To the

The law requires that the death certificate be executed

Box 68760,

P.O.

Division of Vital Records,

Hospital or Attending Physician: 24 hours after death.

Examiner

Physician/Medical

ð

Completed

Be

Certification:

Medical

Depertment of important: If eny injury or once. injury or

**Physician** 

/Medical

Examiner

**Funeral** 

Director

•how

r then "netural", or iteme 23a or 28a-f ehov the Medical Examinar must be notified at

marked other then

12 should be fi h and Mental H 7 le marked ot

Pages 1 and 2 ment of Health a

within 72 hours after

Maryland 21215-0036

Baltimore, I

Director

þ

Completed

Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Immediate Cause (Final disease or condition resulting in death)

a	Pancreatic Cancer
	Due to (or as a consequence of):
b	
	Due to (or as a consequence ol):

Due to (or as a consequence of)

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 2 Yes 2 2 No

23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death

3 Ectopic pregnancy

23d. Date of delivery Month Day

20c. Location - City or Town, State

Long Island, NY

9 Unknown

4□Pregnant at time of death 9 Unknown

5 ☐ Dther (specify)

Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 Yes 2X No 3 Probably 4 Unknown

ij	24a. Was an
1	autopsy
1	performed?
i	1 Yes 2₺ No
J	

28d. Describe how injury occurred

24b. Were autopsy findings available prior to completion of cause of death? 2**℃** No 1 ☐ Yes

Year

26. Place of Death (Check only one)

25. Was case referred to medicat examiner? 1 ☐ Yes 2X No 27. Manner of Death

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Injury

28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify)

Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) 28c. Injury at Work?

1 Tes 2 No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ANaturat

2 Accident

3 ☐ Suicide

4 - Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

5 Pending

investigation

6 Could not be determined

29c. License number D0017211

29d. Date signed (Month, Day, Year) 10-15-06

ted cause of death (Item 23a) (Type, Print) 30. Name and address of person who comp

Hospital:

Kenneth Goldstein, MD 2141 K Street NW Washington, DC 20037

State Registrar 31. Date liled (Month, Day, Year) 2006



State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician 4:25 p M Letwinsky October 2006 R. Elizabeth /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Anne Arundel Crofton Convalescent Center Crofton If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Hours Months Days 1 ☐ M 2 💢 F Director 219-13-4458 94 Dec 5 1911 Pennsylvania Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10b. County 10a State in than "neturel", or Iteme 23a or 28a-f ehow the Medical Extrainer must be notified at 1 ☐ Yes 2 📆 💢 to Director MD Anne Arundel Odenton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21113 TISA 1018 Summer Hill Drive Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. 72 hours after 1 □ Never Married 2 □ Married Maryland 21215-0036 1 ☐ Yes 2X No Specify: White Specify: ģ 3 K Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) ie marked other than College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Own Home 8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 ie marked oth ery Injury or other traumatic event <u>once</u>. Be Mary Haluszczk John Polinsky ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1018 Summer Hill Drive, Odenton, MD 21113 Carl Letwinsky (Son) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State XXBurial 2 Cremation 3 Removal from State 10-13-2006 Rosedale, MD Gardens of Faith 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funefal Service Licens 22. Name and Address of Facility Hardesty Funeral Home, P.A. 12 Ridgely Avenue, Annapolis, MD 21401 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician Gronon /Medical Due to (or as a co sequence of): **Examiner** Sequentially list conditions, if any, reading to intercept accesses. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Qualto (or as a consequence of) The law requires that the deeth certificate be executed ettending physicien and for use as the burial-transit Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy Day Year in the past 12 months? 1 ☐ Yes 2 🖾 No Month 4☐Pregnant at time of death 5 Other (specify) P.O. ed by the detached 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ Records, 1 Yes 2 No 3 Probably 4 Winknown certificate has been sirector, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 XN0 1 Yes 2 No 1 Yes of Vital or Attending Physician: funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 1 ☐ Yes 2 No 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After Division 5 Pending investigation 1 Natural after death. 1 ☐ Yes 2 ☐ No 2 Accident the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, faclory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Hospitel within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) To the 29b. Signature and little of ce 29c. License number 29d. Date signed (Month, Day, Year) MID death (Item 23a) (Type, Print) 30. Name and address of person who completed cause of Olu Burnie MD21061 Sw 31. Date filed Month, Day, 32. Registr Signature State Registrar

		-	1 - For State of Maryland / Dep	partment of Health and Nertificate of Death	Reg. N	11111	34595	
	Physicia		1. Decedent's Name (First, Middle, Last)  Charles La Rosa		2. Date of Death Month Da Oct. 12,		3. Time of Death 12:40a M	
	/Medic Examin		4a. Facility Name (If not institution, give street and number) 1598 Chocataw Road	4b. City, Town, or Location of Death Arnold	40	4c. County of Death  Anne Arundel		
15	Funeral Director	34.	5. Social Security Number  085-01-6209  085-01-6209  085-01-6209  085-01-6209  092  092  092  093  093  094  095  095  095  095  095  095  095	/ If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, Year Sep. 5, 19	9. Birthp Cour	place (State or Foreign htry) NY	
	Aaryland f show	or	10a. State 10b. County 10c. City, Town or I	ocation Arnold		1	0d. Inside City Limits 1 ☐ Yes 2 No	
	or 28a-	Director	10e. Street and Number	10f. Zip Code	10g. C	itizen of What Cour	ntry?	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Itam 27 is marked other than "natural", or Itama 23a or 23a-f show any figury or other traumatic avant, Ita Markinal Exzintrer roual be notified a page.	by Funeral	1598 Chocataw Road  11. Marital Status  1 □ Never Married 2 Married  3 □ Widowed 4 □ Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Yes 2 No If Yes, Give Year or Dates:	21012  . Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto 1  Yes 2 No Specify:	pecify Yes or No- p Rican, etc.)	USA  14. Race - Americ Black, White, Specify: W		
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Maryland 2121	uld be filed Aentat Hygi rked other tic avent, I	To Be Co	17. Father's Name (First, Middle, Last) Pasquale La Rosa	18. Mother's Nam	e (First, Middle, Maide Fascetta			
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Balt	permit. Depart Import any Inj		21. Signature of Funeral Service Licensee	22. Name and Address of Facility Barranco & Sons, P 495 Gov. Ritchie Hu	A. Severna wy, Severna	Park Fu Park, M	neral Home 21146	
8760,	Physician //Medical Examiner  the private reads	lical Examiner	23a. Party Effer the disease, or complications that caused the death. Do not e sheck, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):	lever.			Approximate Interval Between Onset and Death 3days  20 years  20 years	
P.O. Box 6	The law requires that the death certificate be executed ate been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Medical		□Ectopic pregnancy □ Other (specify)		23d. Date of delive Month	ery Day Year	
	w requires that to be by should be detail	5	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacco	use contribute to t		
I Reco	: The law rec cate has bee page 2 shor	Completed			24a. Was an autopsy performed?	prior to co	opsy findings available impletion of cause of	
f Vita	Physician: The Ithis certificate ha	To Be	25. Was case referred to medical examiner?  1 Yes 2 No Hospitaf: 1 Inpatient 2 ER/Outpati	Other	th (Check only one) ome 52 Residence	6 □Other (Special	(y)	
Division of Vital Records,	To the Hospital or Attending Physician: within 24 hours effer death. To the Funeral Director: After this certifics completely filled in by the funeral director, is	Certification:	27. Manny of Death  1 Natural 5 Pending (Month, Day Year)  2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, so building, etc. (Specify)	Work?  M 1 ☐ Yes 2 ☐ No	28f. Location (Street a City or Town, Sta	and Number or Run	al Route Number,	
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<b>\</b>	To the within 7 To the comple	Med	29b. Signature and title of certifier	29c. License number		Pate signed (Month,	,	
•	ID		30. Name and address of person who completed cause of death (Item 23a) (Typ	D39497 2002, Medical 1	Parliwais	Anna:	DOB	
	Sta Regist		31. Date filed (Month, Day, Year) OCT 1 6 2006  32 Registrar's Signature	book	J		-	

			For State Registrar	State of Mary		irtment <i>tificate</i>			Mental Hy	giene Reg. No.	2006	34596
	Physici	an	Decedent's Name (First, Middle, La	est)		_			2. Date of De. Month	Day	Year	3. Time of Death
	/Medic	al	Robert Denton  4a. Facility Name (If not institution, gire			4b. City. T	own, or l	ocation of Dea	October		County of Death	
	Examin	er	Washington Coun					stown			Wash	inaton
	Funeral		Social Security Number 6.		yrs. last birthday)	If Under 1	1 Year Days	If Under 24 Hr Hours Mir		h y, Year)	9. Birth Cou	place (State or Foreign intry)
	Director		212-24-2992 Usual Residence of Decedent	AM 20F	77 Yrs.				June 28,	1929	Wes	t Virginia
	/land		10a. State 10b. County	10	c. City, Town or Lo	cation		·				10d. Inside City Limits
	a-f eh	ctor	Maryland Washi	ngton	На	gerst	own					1 □ Yes 2 □ No
	or 28	Directo	10e. Street and Number			10f. Zip (				10g. Citiz	zen of What Cou	intry?
	e 23a	eral	19809 Jefferso	n Blvd. 12. Was Decedent Eve	rin II S 13 V	Nas Decede	217		Specify Yes or No	. 1	USA 14. Race - Ameri	ican Indian
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	/Medic Examin	aı er	4a Facility Name (If not institution, giv	e street and number)		i	4b. City T	own, or Loca	tion of Death		4c	. County of Deat	h 4
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			30. Name and address of person who	1	. 1	. 1	Print)	POR	30x 173	33 Se	1156	MO	21802
	Sta Registi		31. Date filed (Month, Day, Year)	32½ Regist	trar's Sign	HOS DV	12/20						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene UUb Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** Gloria 1442 Jean Long October 11 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Talbot Easton Memorial Hospita If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1□M XXF 571-64-660 59 Yrs. July 26. 1947 Maryland Director Usual Residence of Decedent 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if Item 27 is marked other then "neturel", or Iteme 23a or 28a-f ehow any Injury or other treumatic event, the Waddeal Examinar must be notified at once. 10b. County 10c. City, Town or Location 10d. Inside City Limits 1√XYes 2 No MD Caroline Director Federalsburg 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 3460 Laurel Grove Road #3D 21632 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 □Yes 2.□No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 💢 No Specify: Specify: þ White 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James Bernard Simms Mildred Viola Loor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Melissa Michaud/Daughter 416 Hickory Lane, Seaford, DE 19973 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition ★ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Federalsburg, MD Bloomery Cemetery 10/16/06 22. Name and Address of Facility Framptom Funeral Home, P.A. 21. Signature of Funeral Service Licensee 216 N. Main St., Federalsburg, MD 21632 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Ogset and Death Immediate Cause (Final disease or condition resulting in death) encepha **Physician** /Medical Examiner proter Eagus ittally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner physiclan and the burial-transit 01 use as t IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No ğ Month Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by dialete 2 No 3 Probably 4 Unknown

Hospitei or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760. rector, page 2 uneral Director: A silv filled in by the fu within 24 hours aft To the Funeral Di completaly filled in

L019 G10I Baltimore, Maryland 21215-0036

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hyperten	tion			2
Coronary	artery	dsene		1
as case referred to medical	0,		26. Pface of Death	(Che
aminer?	Hospital:		Other	

	autopsy performed?	prior to completion of cause of death?
-	1 Yes 2 No	1 ☐ Yes 2 ☐ No
(C	heck only one)	
θ	5 ☐ Residence	G ☐Other (Specify)

006

25. Was case referred to medical			26. Place of Dea	th (Check only one)
examiner? 1 Yes 2 No	Hospital: 1 Inpatient 2	ER/Outpatient 3 De	OA Other: 4 Nursing H	ome 5 ☐ Residence 6 ☐ Other (Specify)
27. Manner of Death 1		28b. Time of Injury M	28c. Injury at Work? 1 □ Yes 2 □ No	28d. Describe how injury occurred
3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Specif	ome, farm, street, factor fy)	y, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)	1 ☐ Certifying Physician: To the best of 2 ☐ Medical Examiner: On the basis of and manner sta	f my knowledge, death occurred at the time, date and place, and examination and/or investigation, in my opinion, death occurred a ed.	due to the cause(s) and manner as stated. at the time, date and place, and due to the cause(s)
29h. Signature-and	title of certifier	29c. License number	29d, Date signed (Month, Dev. Year)

D. Signa		2.1	but	w	6404	3	Octobe	212,2
30. Name	and address of person v	who completed ca	use of death (fter	m 23a) (Type, Print)				21/

State Registrar

Medical Certification:

31. Date filed (Month, Day, Year) 6 2006

DAUL W. Morde



	-	T = For State Registrar						Death			Reg. No.	2006	3459
Physicia		1. Decedent's Name (First, Middle, Last)  Albert	Miller							2. Date of Dea	ath 13 <sup>0</sup> ,	2006	3. Time of Death 11:45P
/Medic Examin	_	4a. Facility Name (If not institution, give s Manor Care	treet and number)			I	otom					County of Deat	
Funeral Director		5. Social Security Number  083-07-2525  Usual Residence of Decedent	M 2□F 7. Ag	95	ast birthday) Yrs.	If Unde Months		If Under a	24 Hrs. Min.	8. Date of Birt (Month, Da April	1, Ye <i>ar)</i>	9. Birti Co Ne	hplace (State or Forei untry) W York
Maryland	tor	10a. State MD  10b. County Queen Ann Montgomer			ovensv	or Location ensville							10d. Inside City Limit
a or 28	I Director	10e. Street and Number 101 Baltimore Ave					p Code 1666					en of What Co J.S.A.	untry?
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Deperment of Heeth and Mental Hygiene. Deperments if them 27 is marked other than "natural", or items 23a or 28a-f show important; if them 27 is marked other than "natural", or items 23a or 28a-f show eny injury or other treumatic event, the Medical Examinar must be notified at once.	by Funeral		12. Was Decedent Armed Forces? 1 ⊠Yes 2 ☐ If Yes, Give Year or Dates:	No		Was Dece If Yes, spo 1 \( \text{Yes}	city Cuba	spanic Orig n, Mexican Specify:	gin? (Spe , Puerto l	ocify Yes or No Rican, etc.)		4. Race - Ame Black, White Specify: Wh	
within 72 hc iene. ' than "netui the Medical	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) 12th  15. Decedent's Usual Occupation (Give kind of work done during not life. DO NOT use retired)  Real Estate				luring most )	on ring most of working 16b.			d of Business/ Private	ŕ		
wild be filed Mental Hyg arked other atic event,	To Be C	17. Father's Name (First, Middle, Last)  Louis Miller								(First, Middle, annenba		Surname)	
nd 2 sho		19a. Informant's Name/Relationship (Type Violet Rason - F:			19b. Mailir 902	ng Addres Malta	s (Street 2 a Lan	e Sil	r or Rura Ver	Spring	or, City or MD	7000 State, 2	Zip Code)
Pages 1 a nent of Hee nut: If Item iry or othe		20a. Method of Disposition 1 ⊠ Burial 2 ☐ Cremation 3 ☐ R. 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	0	lace of Dispo emetery, crei	natory or	me of other plac		0-17	-06		ation - City or phi, MI	
permit. Depentminents Imports eny inju		21. Signature of Funer Service License	<b>96</b>					-		erg Men Rockvi	noria	1 Garde	ens
Cate be executed //Medical bhysicien and sthe burial-fransit	dical Examiner	disease or condition resulting in death)  Sequentially list conditions. If any, leading to in modate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Pneumo Due to (or as Advance Due to (or as	ed De	ementi	a							
The law requires that the death certification has been signed by the attending plage 2 should be deteched for use as to	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome 1 Live birth 4 Pregnant a 9 Unknown	2 Feta	death 3	∃Ectopic p ∃ Other (s	pregnancy				2	3d. Dale of deli Month	ivery Day Year
w requires thet s been signed by should be dete		Part II. Other significant conditions con	tributing to death t	out not res	ulting in the u	nderlying	cause give	en in Part I.					the cause of death?
: The law re cate hes bee ; page 2 sho	Completed		<u></u>							24a. Was autop perfo 1 🗆 Yes		prior to death?	topsy findings availal completion of cause of
Physician: Th r this certificate ral director, pag	To Be	25. Was case referred to medical examiner?  1 Yes 2 No	ospital: 1  Inoati	ent 2 🗆	ER/Outpatier	3 7 0	OA Othe			Check on one one 5 ☐ Resid		Other (Coa	-4.1
Attending Phyrideath.		27. Manner of Death 1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Inju (Month, Da		28b. Time o Injury		28c. Injun Work		2	28d. Describe h			-ny)
2 th 5	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of In building, e	jury - At ho tc. <i>(Specif</i> )	ome, farm, str	reet, facto	ry, office		2	28f. Location (S City or Tox	Street and vn. State)	Number or Ru	iral Route Number,
Hospital     24 hours a     Funeral [     letely filled i	edical	29a. Certifier 1⊠ Certifying Phys (Check only one) 2  Medical Examin	ician: To the best er: On the basis of and manner st	of examina	wledge, deat tion and/or in	h occurred vestigatio	at the time n, in my of	ne, date and pinion, deal	d place, a	and due to the ed at the time,	cause(s) a date and p	and manner as place, and due	stated. to the cause(s)
To the To the compfet	Me	29b. Signature and title of certifier	خر			29	c. License	number			29d. Date	signed (Monti	n, Day, Year)
b		30. Name and address of person who co	mpleted cause of	death (Item	1 23a) (Type,		D0054	4566			10-	16-06	
	}	Sunitha Bhogavilli	. 1220 A	East	.Ioppa	Roa	d Su-	ite 2	30 -	Poweon	MD 1	21286	

State of Maryland / Department of Health and Mental Hygiene 005 Certificate of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death OCTOBER **Physician** 8:38 P M MAZZARELLA **VERONICA** 2006 ROSETTA /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner MONTGOMERY OLNEY 17504 GATSBY TERRACE | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | FEB. | 11, 1917 Birthplace (State or Foreign Country)
 NEW YORK 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 🛣 F 89 065 16 0836 Director Usual Residence of Decedent 10c. City, Town or Location id 2 should be filled within 72 hours after death with the Maryland. Ith and Mental Hygiene. 27 ie marked other then "natural", or terma 23a or 28a-f ehow traumatic event, the Madical Examinational te multilied at 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 No Director MD. MONTGOMERY OLNEY 10e Street and Number 10f, Zip Code 10g. Citizen of What Country? 17504 GATSBY TERRACE 20832 UNITED STATES Funerai 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerlo Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 X Never Married 2 ☐ Married ☐Yes 2 Mo f Yes, Give ltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: WHITE þ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) **EDUCATION** College (1-4or 5+) TEACHER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Antonino Mazzarella Teresa Coloraffi ం 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) s 1 end 2 s if Health an item 27 ie Phyllis Gagliardo, Sister 17504 Gatsby Terrace, Olney, Md. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Depertment of H
important: if ite
eny injury or ott 1 Burial 2 Cremation 3 Removal from State 10/20/06 Calvary Cemetery Woodside, New York 4 ☐ Donation 5 ☐ Other (Specify) 21. Sign were of Funeral Service Livensee MURTEL HOME BARBER FUNERAL HOME M - 00470 P.O. BOX 5038, LAYTONSVILLE, MD. 23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Multiple Myeloma /Medical Due to (or as a consequence of) Examiner dementia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine certificate be executed physicien and s the burial-transit Due to (or as a consequence of) Box 68760 Physician/Medical ettending p IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 \( \subseteq \text{Yes} \quad 2 \subseteq \text{No} \) Month Day Year 4☐ Pregnant at time of death 5 ☐ Other (specify) ed by the e o 9 Unknown ۵ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 PNo cete has been sig , page 2 should b 3 Probably 4 Unknown Completed 24a. Was an autopsy performed?
1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificete Division of Vital funeral director Be 25. Was case referred to medical 26. Place of Death [Check only one] examiner Cther: 4 ☐ Nursing Home 5 ■ Residence 6 ☐ Other (Specify) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA 1 ☐ Yes 25 No ဥ After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? To the Hospital or automatical within 24 hours effer death.

To the Funeral Director: Aftr 1 Natural 5 Pending 1 □ Yes 2 □ No 2 Accident investigation M 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) October 16, 2006 w D39190 of death (Item 23a) (Type, Print) 3418 OLANDWOOD CT. #111, OLNEY, MD. 20832 J. GARRETT REILLY, M.D. 32 Registrar's Signature 31. Date filed (Month, Day, Year) State 2006

DHMH 17 Rev 1/2001

Registrar

#### 06-07857

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

Darrien Moses M			te of Marylar				nd Ment	al Hygiene		
		I-For State Registrar 1. Decedent's Name (First, Middle	( cot)	Certifi	icate of	Death		2. Date of De	Reg. No. 200	5 3460
Physicia Medical Examir	ner	Darrien	Moses	Mom				Month October	19, 2006 Year	0849 hrs
		4a. Facility Name (if not institution Shady Grove Hospital	give street and num	ber)		4b. City, Town, o Rockville	r Location o	f Death	4c. County of Deat  Montgomery	h
Funeral			S. Sex 7.	. Age (In yrs last b	birthday)	If Under 1 Yea	ar If Unde	r 24Hrs 8. Date of B	firth(MM/DD/YYYY) 9 Bi	rthplace (State or
Director		None	1X M 2 F		Yrs	Months Day	ys Hours	Min. July	13,200 Fore	gn ountry) MD
	Ì	Usual Residence of Decedent					2-1			
w any		10a. State 10b. County		10c. City, Tov						10d. Inside City Limits
yland -f sho	ģ	MD Monto	omery	Ga	ltne:	rsburg		<del></del>	10g. Citizen of What Cou	1 X Yes 2 No
imore, MD 21215-0036  Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene  taut: If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be untiffed at once.	Director	17904 Cotton	wood Te	rr			877		U.S.A.	ind y?
eath with items 2 ust be u	Funeral	11. Marital Status  1 Xuever Married 2 Mar	Asses J Ford	dent Ever in U.S. ces? 2 X No				in? ( Specify Yes or N Puerto Rican, etc.)	lo- 14. Race - Ame White, etc.	ican Indian, Black,
after d	J. F.		rced If Yes, Give Year or Dates:		1	Yes 2 X No			Specin,	lack
hours		15 Decedent's Education (Speci Elementary/Secondary (0-12)	fy only highest grade  College (1-4			it's Usual Occupa ost of working life		and of work done use retired)	16b. Kind of Business	'Industry
1036 vithin 72 ene er than Medical	Completed	0		4 51 5 . )	1	None			None	
21215-0036 uld be filed within 7 Mental Hygiene marked other than r event, the Medica	Be Co	17. Father's Name (First, Middle, L	·					s Name (First, Middle	,	
212 uld be Mente mark	<u>ල</u>	Max Momoh  19a. Informant's Name/Relationsh	ip (Type, Print )		19b. Mailing	Address (Stre	Me et and Num	lissa Ri ber or Rural Route Nu	eger umber, City or Town, State	e, Zip Code)
MD d 2 sho lth and n 27 is		Max Momoh- F	ather							rg,MD20877
or Heal		20a Method of Disposition  1 XBurial 2 Cremation	3 Removal from	n State crem	natory or otl	ition (Name of ce ner place)		Date	20c. Location - City of	
Baltimore, Pernit Pages I as Department of He Important: If ite		4 Donation 5 Other Spe		All		Ls Cem			Germanto	
Baltimore permit Pages I Department of I Important: If		21 Sign ture of Funeral Service L	icense	- hod						le,MD20850
Physician	4	23% Fart I. Enter the disease, or co		used the death. Do						Approximate Interval
/Medical Examiner		failure List only one cause of Immediate Cause (Final disease	a Sudden in	nfant death	syndr	ome				Between Onset and Death
		or condition resulting in death)	Due to (or as a c	consequence of):						
	je	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a c	consequence of):					-	
=	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a c	consequence of).						1
iO,  e be executed ysician and burial - transit	Ě	ordina resenting in deatily Edec	d							
0, e be executed rsician and burial - trans	edical	X UNPENDED	AMENDED #	23a,27,per	ME.	g862, 12/1	L4/06 T	Т		
68760 certificate nding phy	n/M	IF FEMALE: 23b Was decedent pregnant in the	23c. If yes, ou	utcome of pregnan	су	tal death 3		pregnancy	23d Date of deliver Month	y Day <b>Y</b> ear
Box 6i	hysician/M	past 12 months?  1 Yes 2 No 9 Unkr	4 Pregnar	nt at time of death		her (Specify)		F 3,		
). BC	Phys	Part II. Other significant condition	9 Unknow	vn death but not resul	Iting in the i	inderlying cause	given in Par	rt1 23e Did	tobacco use contribute to	the cause of death?
tal Records, P.O. Box 6876 cian: The law requires that the death certificat certificate has been signed by the attending phyector, page 2 should be detached for use as the	2	•					9.70	1 Y		
of Vital Records, g Physician: The law require ther this certificate has been si meral director, page 2 should b	Completed							24a. Was		utopsy findings available completion of cause of
eco he law ate has	duo					· · · · · · · · · · · · · · · · · · ·			ormed? death?	
al R	Be C	25. Was case referred to medical examiner?				26.Plac	-	Check only one)		
of Vit mg Physic After this c	2	1 <b>Y</b> es 2 No		patient 2 🗸 ER				Nursing Home 5	Residence 6 Othe	r:
n of \index or or or or or or or or or or or or or	ion:	27. Manner of Death  1 X Natural 5 Pendi	28a. Date of (Month, D	f Injury 28 Day,Year)	b. Time of I		ury at Work? Yes 2		how injury occurred	
Division rale or Attendin rs after death all Director: A led in by the fu	icat	2 Accident Invest	igation 28e Place	of Injury - At home	, farm, stre				(Street and Number or Re	ural Route Number, City
Division Hospital or Attent 24 hours after death Funeral Director: stely filled in by the	Certification:	3 Suicide 6 Could 4 Homicide determ	not be				0	or Town,		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the b	Medical C		niner: On the basis of	examination and/o					use(s) and manner as star e and place, and due to the	
To with To con	Mec	29b. Signature and title of certifier	and manner sta	ited			se number		29d Date signed (Mo	
		Colinea	vr A	20		0.0	.M.E.		October 20, 200	6
		30. Name and address of person v		•	,	- 01 : 5 :		AD 24204	1	
	oʻr.		ssistant Medica	istrar's Signature	111 Per	in Street, Bal	umore, N	/IU 21201		
St Regist	ate rar	31. Date filed (Month, Day Year) 0CT 2 6		ever II.	(Sport	No.				

			•	of Maryland / Depa	artment of Health and I	Mental Hygie	•	34602
	Dhyoloir	200	Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day Year	3. Time of Death
	Physicia /Medic	al	John Josep		ermott, Jr.	0ctober	9 2006	0320 M
	Examin	er	4a. Facility Name (If not institution, give street and no		4b. City, Town, or Location of Deat	1	4c. County of Death	
	£		Anne Arundel Medical  5. Social Security Number 6. Sex	7. Age (In yrs. last birthday)	Annapolis If Under 1 Year If Under 24 Hrs	_ 8. Date of Birth	Anne A	
	Funeral Director		219-64-0319  Usual Residence of Decedent	51 Yrs.	Months Days Hours Min.	(Month, Day, ) June 3		place (State or Foreign ntry) ington, DC
	within 72 hours after deeth with the Maryland ene. Than "natural", or Items 23a or 28a-f ehow ha Macical Exacili er regal be notified at		10a. State 10b. County	10c. City, Town or Lo	ocation			10d. Inside City Limits
	Mar-fet	tor	MD Anne Arundel	Arnold				1 ☐ Yes ANO
	or 28	Director	10e. Street and Number		10f. Zip Code	100	. Citizen of What Cou	ntry?
	23a	ral	413 Martingale Lane		21012		USA	
	or dec	Funeral	Armed F	cedent Ever in U.S. 13. orces?	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer	pecify Yes or No- o Rican, etc.)	14. Race - Ameri Black, White,	
36	s afte	by F	1 ☐ Never Married 2 ፟ Married 1 ☐ Yes If Yes, G 3 ☐ Widowed 4 ☐ Divorced Year or		1 ☐ Yes 2 🔀 No Specify:		Specify:	White
8	hour turai	pa pa	15. Decedent's Education		dent's Usual Occupation	16	3b. Kind of Business/Ir	ndustry
15	J within 72 hours after deeth with the Marylan jiene. Ithan "natural; or liems 23a or 28a-1 show Itha Medical Executive mast be inclifted at	plet	(Specify only highest grade completed	(Give	kind of work done during most of wo DO NOT use retired)	rking		,
212	70 50 50 50	Completed	Elementary/Secondary (0-12) College	(1-4or 5+) Sal	es		Industria	1
밀	0 = 0 5	BeC	17. Father's Name (First, Middle, Last)		18. Mother's Na	ne (First, Middle, Ma	aiden Sumame)	
Ma		2	John J. McDermott		Patri	cia Kay P	rice	
Maryland 21215-0036	and and and		19a. Informant's Name/Relationship (Type, Print)		ing Address (Street and Number or Ri			o Code)
d)	lan leal in 2		Gail McDermott (Wife)  20a. Method of Disposition		Martingale Lane,		MD 21012 Oc. Location - City or To	own State
Baltimore,	if ite		1 ☐ Burial 2 X Cremation 3 ☐ Removal from	ii State	osition (Name of matory or other place)			
Ħ	nit. Paradmen ortent: injury 9.		4 Donation 5 Other (Specify)	Metro Cro	ematory 10- 2. Name and Address of Facility	10-2006	Baltimore,	MD
Ba	permit. Pages 'Department of Himportent: if Ite any injury or of pages.		21. Signature of Funeral Service Ticeasee	2	Hardesty Funeral	Home, P	A.	
1 4	*		23a. Part1. Enter the disease, or complications that	caused the death. Do not en	12 Ridgely Avenu ter the mode of dying, such as cardia			Approximate
	Physician		shock, or heart failure. List only one cause on Immediate Cause (Final	each line.	Basi la	20 11 1		Interval Between Onser and Death
1	/Medical		disease or condition resulting in death)  Due to	o (or as a consequence of):	Bran dor	yc		64
	Examiner		Sequentially list conditions b.	Repust	on arriv			
-00	р <del>Ц</del>	lner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	o (or as a consequence of):				
	ecute and trans	Examiner	that initiated events C.	o (or as a consequence of):				
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687	icate phys s the		d					
Вох	leath certificat attending phy I for use as the	√Me		utcome of pregnancy			23d. Date of deliv	ery
ă	death a atte	Iclai	in the past 12 months?	gnant at time of death 5[	Ectopic pregnancy Other (specify)		Month	Day Year
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<u>~</u>	ysicien: The is certificate hadirector, page	Co	Herry N	AFIR	•	performe 1 ☐ Yes 2	death?	2 ☐ No
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ou	ding h. After tunel	ţ	Talada a a a a a a a a a a a a a a a a a	e of Injury 28b. Time onth, Day Year) Injury	of 28c. Injury at Work?  M 1 ☐ Yes 2 ☐ No	200, 200001001100	injury occurred	
Division	Attendia death. ctor: A y the tu	fica	3 Suicide 6 Could not be determined 28e. Plac	ce of Injury - At home, farm, st			et and Number or Run	al Route Number,
ē	el or A after i Dire d in by	Certification:	4 Homicide determined buil	ding, etc. (Specify)		City or Town,	State)	
	To the Hospitel or Attending Physicien: The law requires that the death certifica within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending photon Property of the funeral director, page 2 should be detached for use as the completely filled in by the funeral director, page 2.	Medical C	(Check only 2 Medical Examiner: On the	he best of my knowledge, dea basis of examination and/or in inner, lated.	th occurred at the time, date and place exestigation, in my opinion, death occurrence	a, and due to the cau urred at the time, dat	ise(s) and manner as s e and place, and due t	stated. to the cause(s)
	To the within To the comp	M	29b. Signature and title of certifi r	01	29c. License number	290	d. Date signed (Month,	Day, Year)
)			MM all a	1 won	1) 214	38	10/10/0	2
	(2)		30. Name and address of person to Ampleted ca	use of death (Item 23a) (Type	DEKENSE HGHO	VAY ANN	PULIS MA	L1401
	Sta Registr		31. Date filed (Month, Day, YOCT 16 200	Registrat Signature	Spark			

State of Maryland / Department of Health and Mental Hygien 34603 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year Physician 12:45 A Oct 15 2006 <u>Althea Dailey Molitor</u> /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Calvert Solomons 11750 Asbury Circle AL122 If Under 1 Year If Under 24 Hrs. Months Days Hours Min. July 25 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** <sup>4</sup>1313 1 □ M 2 □ F 93 Yrs Connecticut Director 042-16-1626 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Itams 23a or 28a-f ahov amy Injury or other traumatic event, the Medical Exem har must be notified at once. 1 ☐ Yes 2X No Solomons Maryland Calvert Directo 10g. Citizen of What Country?
United States 10e. Street and Number 10f. Zip Code 20688 11750 Asbury Circle AL 122 by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 ☐ No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify Yes, Give Specify white 3 Widowed 4 Divorced Year or Dates Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Union secretary 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Edith Irene Woods John Francis Dailey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 43981 Autumnwood Lane California MD 20619 Judith Carrigan- daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Oct 16 2006 Hanover MD 4 Donation 5 ☐ Other (Specify) Anatomy Gifts Registry 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rausch Funeral Home 4405 Broomes Is. Rd. Port Republic MD Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition espilatin Physician resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Completed by Physician/Medical Examiner Due to (or as a consequence of): ettending physicien and for use as the burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time ol death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day 5 Other (specify) 1 ☐ Yes 2 No 9 ☐ Unknown be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown peeu 24b. Were autopsy lindings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 autopsy performed? certificate 1 ☐ Yes 2 No or Attanding Physician: Medical Certification: To Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No this 28a. Date of Injury (Month, Day Year) within 24 hours after death.

To the Funeral Director; After th completely filled in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation M 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 28l. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide To the Hospital red Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier Ja 225 72 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) J. John Barth, III, M.D. 110 Hospital Rd Suite 310 Prince Frederick, MD 20678 32. Registras Signature 31. Date filed (Month, Day, Year) State OCT 1 8 2006 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 10 6

34604

		1	For State Registrar	Sia	te or ivi	arylanu / L	•	icate of	Death	MEHIAI II	Reg.		U	J 4 0 0 4
П			1. Decedent's Name (First, Mic	ldle, Last)						2. Date of I	Death	Davi V		3. Time of Death
	Physici		Helen		Mae 1	Moore				Month	1 =		ear L	0131 4
	/Medio		Helen Mae Moore  4a. Facility Name (If not institution, give street and number)			41	4b. City, Town, or Location of Death			Ť	4c. County of I		0.01	
	Examil	lei	Penlasuca Regions			restan		(A) (I)				Homico		
			5. Social Security Number	6. Sex		e (In yrs. last bir	thday) If	Under 1 Year	If Under 24 Hrs	B. Date of E	Birth			lace (State or Foreign
	Funeral Director		007-26-9709 Usual Residence of Decedent	1□ M 2				onths Days	Hours Min.	(Month, 1 – 25 – 1	Day, Ye	ear)	Coun ain	ntry)
	Due *		to the control of the							0d. Inside City Limits				
	a-f eho	Funeral Director	MD Wicomico Delmar							1 ☐ Yes 2∭ No				
	7 28 E	ire	10e. Street and Number					10f. Zip Code			10g.	. Citizen of Wha	t Cour	itry?
	h wit	0	8747 Shell Roa	ad				21875			.	USA		
	deat	Jer	11. Maritaf Status			Ever in U.S.	13. Was	Decedent of H	lispanic Origin? (S an, Mexican, Puer	pecify Yes or I	No-	14. Race -		
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelth and Mental Hygiene. Importent: If item 27 is marked other than "naturel", or items 23a or 28s-f ehow any injury or other traumatic event, its Mudical Exartities must be multiled at ODGs.	by Fur	1 ☐ Never Married 2 N N 3 ☐ Widowed 4 ☐ Divord	arned 1 [	ned Forces? Yes 2 <u>K</u> ] es, Give ar or Dates:			Yes 2X No	Specify:	to Hican, etc.)		Specify:		etc. ite
ĕ	hou	ed	15. Deced	ent's Education		16a	. Decedent	's Usual Occup	pation		161	b. Kind of Busin	ess/Inc	dustry
5	in 72	jet	(Specify only hig	hest grade comp			(Give kin)	d of work done NOT use retired	during most of wo	rking	100	D. 111110 0. D0011		2001.)
2	with the che.	Completed	Elementary/Secondary (0-12	() Col	lege (1-4or	5+)		memake				Own Ho	m o	
N 0	be filed of the bed of the filed  ŭ	17. Father's Name (First, Midd	le. Last)				in o in care o	18. Mother's Na	me (First, Midd	tle. Mai		ше		
ä	od o	Be										,		
Ë	1 Me	10	Thomas Joudne  19a, Informant's Name/Relation	<del>-</del>		401					Joudrey ral Route Number, City or Town, State, Zip Code)			
Maryland	le st		_		11)	- 1						ity or Town, Sta	ite, <i>Lip</i>	Code)
	and eeith m 27		James Moore -	husband					oad, Delm					
Baltimore,	of H of H if ite		20a. Method of Disposition 1 ⊠ Burial 2 ☐ Crematic	n 3 🗆 Remova	I from State	20b. Place o cemete	ry, cremate	on (Name of - ory or other plac	ce)	Date	200	c. Location - Cit	y or To	wn, State
Ě	Pag nent ant: I		4 Donation 5 Other			Spring	hill	Memory	Gds 10-1	7-2006	F	Hebron,	MD	
a T	mit.	1	21. Signature of Funeral Servi	ce Licensee	11	1	22. N	ame and Addre	ess of Facility Bo	ounds F	unei	ral Home	Δ	
m	Depa Impo any it		11/650	Leen !	Dal	60								14
			23a. Part I. Enter the disease, or completations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.  Approximate											
			shock, or heart failure. List op one cause on each line.  Interval Between Onset and Death											
	Physician /Medical		disease or condition \\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\											
	Examiner		Due to (or as a consequence of):  Sequentially list conditions  b. Coronary Artery Distose											
ı		<b>3</b> -0												
	be sit	ine	cause. Enter Underlying	Į į	oue to (or as	a consequence	Of J?							
	ecute and tran	Examiner	Cause (Disease or injury that initiated events c											
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	ng pl	Jed	F CEMALE.									1		
Box	th ce	Physician/N	tF FEMALE; 23b. Was decedent pregnant			of pregnancy 2 Fetaf death	3 □Fc	topic pregnance	v.			23d. Date o		
<u> </u>	deat e ett	ICIE	in the past 12 months? 1 ☐ Yes 2 ☐ No	4	Pregnant a	t time of death		her (specify)	,		_	Month		Day Year
P. 0.	the by th	hys	9 □Unknown	9L	Unknown									
Division of Vital Records, P	tha ned t	by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to the cause of death?					
	uires Is sign	D D							1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Winknown					
	v req beer shou	Completed								24a. W		24h Wo	ro ato	psy findings available
	e lav	d E								au	as an itopsy irforme	prio	r to cor	nptetion of cause of
=	cate	ပိ								1 Tes				2 No
/ité	cien ertifi ector	Be	25. Was case referred to medical examiner? 26. Place of Death Check only one											
Ž	hysi his c	2	1 ☐ Yes 2 💢 No	Hospita	i ja inpati		utpatient	3□ DOA O	ner: 4 🗆 Nursing I	Home 5□Re	sidenc	e 6 Other	Specif	y)
<u></u>	ng P fter t nera	ü	27. Manner of Death 1 Natural 5 □ Per	28a	. Date of Inj (Month, Da	ury 28b.	Time of Injury	28c. Injui Wor	ry at rk?	28d. Describ	e how	injury occurred		
<u>ō</u>	Attending r death.	atic	1 Natural 5 Pending (Month, Day Year) Injury Work? 2 Accident investigation M 1 Yes 2 No											
<u>×</u>	Atte	110	3 Suicide 6 Could not be determined 28e. Place of fnjury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)					
ā	al or after	Certification:	1 110.110.100		building, e	ic. (Specify)				Ony or	i Own, S	olale)		
	To the Hospital or Attending Physicien: The law requires that the death cerwithin 24 hours after death.  To the Funeral Director, After this certificate has been signed by the ettendin completely filled in by the funeral director, pege 2 should be deteched for use	edicai C	29a Certifier (Check only one)  12 Certifying Physician: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
	o the control of the	Z e	29b. Signature and title of cer					29c. Licens	se number		29d	. Date signed (//	Month.	Day, Year)
	F3F8/													
7	Que.								0/12/06					
	19	17	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)											
	0		Frank Arena, mD 400 Eastern Store Drive, Salisbury MD 21804											
		ate	31. Date filed (Month, Day, Yo	1 6 2006	32. Regist	rar's Signature	1							
	Regist	rar	001	T 0 2000	Men	we st	1900	when the						
	MALI 47 Day 45	1004												

Edward James Moore

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

2006 34605

		1- For State Critical State of Many and 7 Departs	ificate of Death	, .	g No.				
∉ Physicia	in/	Decedent's Name (First, Middle, Last)		Date of Death     Month	Day Year	3. Time of Death 0420 hrs			
ledical Exami	ner	EDWARD JAMES MOORE  4a Facility Name (if not institution, give street and number)	4b. City. Town, or Location of	August 8, 2	4c. County of Death	0420 1115			
		Prince George's Hospital Center	Cheverly	Bodin	Prince George	s			
Funeral		5. Social Security Number 6 Sex 7. Age (In yrs last			n(MM/DD/YYYY) 9 Birth Foreign				
Director		223-62-3856   1XM 2 F   58	Yrs. Months Days Hours	Min. MARCH	30,1948 Cou	ntry) MA.			
,	ļ	Usual Residence of Decedent  10a State 10b County 10c City, To	own or Location			10d Inside City Limits			
ow any			RIVERDALE			1 Y Yes 2 No			
faryland 28a-f show Lat once.	햠	MD. PRINCE GEORGES  10e. Street and Number	10f. Zip Code	10	g Citizen of What Coun	21			
the Ma n or 28	Director	6721 HAMILTON ST.	20737		U.S.A.				
AD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiewith 12 hours after death with the Maryland 21's marked other than "natural", or items 23a or 28a-f she marice event, the Medical Examiner must be notified at once	Funeral	11. Marital Status 12. Was Decedent Ever in U.S.	. 13. Was Decedent of Hispanic Original If Yes, specify Cuban, Mexican,			an Indian, Black,			
r death or ite	F.	1 Yes 2 X No							
rs afte ural",	à	3 Widowed 4 XDivorced If Yes, Give Year or Decedent's Education (Specify only highest grade completed) 1:	1 Yes 2 X No specify  16a Decedent's Usual Occupation (Give ki	Specify WHI  16b Kind of Business/Ir					
72 hou	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	during most of working life. DO NOT u	ise retired)		·			
21215-0036 Id be filed within 72 Aental Hygiene narked other than 'event, the Medical	du	12	ELECTRICIAN		UNION				
filed v Hygi d oth	ပို	17. Father's Name (First, Middle, Last)	18.Mother's	Name (First, Middle, M					
2121 hould be fil and Mental Is is marked trie event,	മി	EDWARD JAMES MOORE  19a. Informant's Name/Relationship (Type, Print )	19b. Mailing Address (Street and Numb	KATHLEEN Der or Rural Route Num		Zip Code)			
and 2 shouled the and 7 tem 27 is retraumatie		BETH REYNOLDS/STEP DAUGHTER	4533 RIDGE DR., BA	ALTIMORE, M	D. 21229				
more, MD 21215-003. Pages I and 2 should be filed within the or of Health and Mental Hygiene unt: If ritem 27 is marked other Ur other traumatic event, the Men			ace of Disposition (Name of cemetery, ematory or other place)	Date	20c. Location - City or	Fown, State			
more Pages I nent of F ant: If i			AMBERS CREMATORY	AUG. 10,06	RIVERDAL	E, MD.			
Baltimore, permit Pages lat Department of Hec Important: If ite injury or other tr		21. Signature of Funeral Service Licensee	22 Name and Address of Facility CHAMBERS FUNER	AL HOME & C	REMATORIUM,	P.A.			
Physician		23a. Part I. Enter the disease, or complications that caused the death. D	Do not enter the mode of dying, such as ca	rdiac or respiratory arre	RDALE, MD.	2073 / Approximate Interval			
/Medical		tailure fist only one cause on each line Tower Sastron	ntestinai bieeu compilica	ишg		Between Onset and Death			
Examiner		Immediate Cause (Final disease or condition resulting in death)  a Hypertensive atherosclerotic cardiovascular disease  Due to (or as a consequence of):							
Market 2	_	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):							
	Examiner	cause Enter Underlying Cause							
ed nsit	Exar	events resulting in death) Last	:						
<b>Records, P.O. Box 68760,</b> The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial - transit		d.  X UNPENDED AMENDED#22 27	ME 061 11/0/06 PP	-					
760, cate be er physiciar	Medical	IF FEMALE: 23c. If yes, outcome of pregna			23d. Date of delivery				
68760, certificate be adding physicise as the buri	sician/	23b. Was decedent pregnant in the past 12 months?	2 Fetal death 3 Ectopic	pregnancy	Month D	ay Year			
Box 687 re death certificate attending	ysic	1 Yes 2 No 9 Unknown 9 Unknown	5 Other (Specify)			- 1			
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S, P.	d pe				2 No 3 Prob				
cords, law requir has been a	ompleted			24a Was a autops	sy prior to co	opsy findings available of ompletion of cause of			
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ital Rec ician: The s certificate rector, page	Be (	25. Was case referred to medical examiner?  1 Ves 2 No	26.Place of Death ( ER/Outpatient 3 DOA Other		Residence 6 Other:				
n of Vit ding Physic After this	: To	27. Manner of Death 28a. Date of Injury 2	28b. Time of Injury 28c. Injury at Work?		Residence 6 Other:				
ion (tending eath.	tion	1 X Natural 5 Pending (Month, Day, Year)	1 Yes 2	No					
Division of Vital Records, pital or Attending Physician: The law requincras after death.  eral Director. After this certificate has been a filled in by the funeral director, page 2 should b	ertification:	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At hom	me, farm, street, factory, office building, etc	28f. Location (S or Town, St	treet and Number or Run	al Route Number, City			
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Divisior  To the Hospital or Attend within 24 bours after death. To the Funeral Director: completely filled in by the:	ical	Certifying Physician: To the best of my knowledge one)  2 Medical Examiner: On the basis of examination and							
To To To Con	Medica	and manner stated.  29b. Signature and title of certifier	29c License number		29d. Date signed (Mon				
		Mhra Brasill MD	O.C.M.E.		August 8, 2006				
		30. Name and address of person who completed cause of death (Item 2			L				
		Melissa Brassell, MD Assistant Medical Examine		, MD 21201					
S Regis	tate trar	00=040000 6.	H. Speek						
DHMH 17 Rev 1/2		4 3 4	ORIGINAL						

State of Maryland / Department of Health and Mental Hygierfe

1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death Year **Physician** James Davis Oliver, Jr. 2115 October 10 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Medical Center Annapolis Anne Arundel 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days 1**X**) M 2□ F Hours Yrs. Director 420-52-5904 May 20 1921 85 Alabama Usual Residence of Decedent with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Item 27 is marked other than "netural", or Items 23e or 28e-f show other traumatic avant, the Medical Examinar must be notified at 1 ☐ Yes 2 X No Director Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 100 Severn Avenue, Apt. 608 21403 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. is 1 and 2 should be filed within 72 hours after of Health and Mental Hygiene. Item 27 is marked other than "netural", or Itel 1 Never Married Married Baltimore, Maryland 21215-0036 1 ☐ Yes 21 No à If Yes, Give Year or Dates: 1942-72 Specify: White 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 16b. Kind of Business/Industry et during most of working Compl Elementary/Secondary (0-12) College (1-4or 5+) Officer United States Navy 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James Davis Oliver Neva Bell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mariella Oliver (Wife) 100 Severn Avenue, Apt. 608, Annapolis, MD 21403 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages
Department of I
Important: If Ite
any injury or of 1 ☐ Burial 2XXCremation 3 ☐ Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory 10-12-2006 | Baltimore, MD 21. Signature of uneral Service License 22. Name and Address of Facility Hardesty Funeral Home, P.A. 12 Ridgely Avenue, Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Vagarba Accolant Corobel disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions of cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner The law requires that the death certificate be executed physician and s the burial-transit resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 Yes 2. Two 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 1 ☐ Yes 2 ☐ No 1 Yes 2 No of Vital To the Hospital or Attanding Physician: Be 25. Was case referred to medical 26. Place of Death Check on one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 Impatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of Certification: 28d. Describe how injury occurred After Division 1 Aatural 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation Diractor 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical The destroying rhysicians to the best of hy knowledge, death occurred at the limit, date and prace, and due to the cause(s) and manner as stated.

2 ☐ Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 To the 29d. Date signed (Month, Day, Year) 10/11/00 P 26373 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Solomons al 75/ PS 1 6 2006 Register 31. Date filed (Month, Day Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) October 12 **Physician** 2006 1:15 a<sup>M</sup> Ontko /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Crofton Convalescent Center Crofton Anne Arundel If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 TYF 89 April 16 1917 New York Director 078-01-2461 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours elter death with the Maryland nent of Health and Mentel Hyglene.
ant: if item 27 ie marked other then "naturel", or iteme 23a or 28a-1 show ury or other treumatic event, its Medical Examinant be riciliaed at ury or other treumatic event, its Medical Examinant be riciliaed at 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Directo MD Crofton Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2131 Davidsonville Road 21114 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 ☐Yes 2 XNo 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White ģ Specify: 3 X Widowed 4 Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Stephen Machalek Elizabeth Kolar 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Ontko (Son) 2476 Wintergreen Way, Gambrills, MD 21054 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages Department of H Important: if its any injury or of 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Wlovak Catholic Cem 10-17-2006 Binghamton, NY 21. Signature of Eugeral Service Licensee 22. Name and Address of Facility Dut Hardesty Funeral Home, P.A. 12 Ridgely Avenue, Annapolis, MD 21401 23a. Part1. Enter the Isease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death tmmediate Cause (Final Physician Acute ononary Weeks disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner theroschero Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed the attending physicien and ched for use as the burial-transit Due to (or as a consequence ot): Division of Vital Records, P.O. Box 68760 Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Dav 4☐Pregnant at time of death 5 Other (specify) ☐ Yes 2 ☐ No deteched 9 Unknown 9 Dinknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an hes autopsy performed certificete 2 X No 1 Yes Hospital or Attending Physicien: filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 No 1 Inpatient 3□ DOA 2 ER/Outpatient Director: After this 28a. Date of Injury (Month, Day Year) Certification: 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how intury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28t. Location (Street and Number or Rural Route Number, City or Town, State) Place of tnjury - At home, tarm, street, tactory, office building, etc. (Specify) 4 Homicide 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the nause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier 24 and manner stated within 2 To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Cholla MD D20108 30. Name and address of person who completed cause of death (frem 23a) (Type, Print) 14300 Gallant Fox Lane, Suite 221, Bowie, MD 20715 Rakesh Arora, MD 2006 Segistrate Signature 31. Date filed (Month, Day, State Registrar

DHMH 17 Rev 1/2001

1 Decedent's Name (First, Middle, Last)  Alice Hintlian Peltekian  1 State Registre AMFND#20a, b, c, perFH10/19/06, PMW, Mon Certificate of Death Month Day 10-12-200	006 34608				
	3. Time of Death 11:45am <sup>M</sup>				
/Medical  4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death  4c. Co	unty of Death				
ROCKVITTE	9. Birthplace (State or Foreign				
Funeral Director  5. Social Security Number  6. Sex  1 M 2X F  7. Age (In yrs. last birthday)  1. Global Feat House Min.  Norths Days Hours Min.  1. Global Feat House Min.  1. Age (In yrs. last birthday)  1. Global Feat House Min.  1. Age (In yrs. last birthday)  1. Global Feat House Min.  1. Day, Year)  1. Social Security Number  5. Social Security Number  5. Social Security Number  6. Sex  1. Age (In yrs. last birthday)  1. Global Feat House Min.	Washington, DC				
	10d. Inside City Limits 1 ☑ Yes 2 ☐ No				
MD Montgomery ROCKVIIIe  106. Street and Number  107. Zip Code 109. Citizer	n of What Country?				
11128 Luxmanor Road 20852	USA				
The Never Married 2/TV Married 1 Tyes 27 No	Race - American Indian, Black, White, etc. Decify: White				
1   1   1   1   1   1   1   1   1   1	. Kind of Business/Industry				
No part of the state of the sta					
19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or To					
0 - FEE	rion - City or Town, State				
21. Signature of Funeral Service Licensee  22. Name and Address of Facility  Joseph Gawler's  5130 Wisconsin Ave., NW Washington					
23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Ust only one cause on each line.  Physician  Primary Brain Tumor	Approximate Interval Between Onset and Death Six Months				
/Medical resulting in death)  a					
Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):					
Cause (Disease or injury that initiated events resulting in death) Last  Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  d.					
X O G G G G G G G G G G G G G G G G G G	23d. Date of delivery  Month Day Year				
9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use	Did tobacco use contribute to the cause of death?  1 Yes 2\sum No 3 Probably 4 Unknown				
24a. Was an autopsy performed?  1   Yes 2   X   X   1   Yes 2   X   X   X   X   X   X   X   X   X	24b. Were autopsy findings available prior to completion of cause of death?  1 Yes 2 No				
1   Yes 2 No   1					
The spiral control of the spiral control of	ccurred				
1 Inpatient 2 EMOutpatient 3 DOA 4 Nursing Home 5 M Hesidence 6 E 27 Mapner of Death 27 Mapner of Death 1 Month, Day Year) 28b. Time of Injury Mork? 2 Accident 2 Accident 2 Accident 3 Suicide 6 Could not be 2 Suicide 6 Could not be 2 Suicide 6 Could not be 2 Suicide 6 Could not be 2 Suicide 6 Could not be 2 Suicide 6 Could not be 2 Suicide 6 Could not be 2 Suicide 6 Could not be 2 Suicide 6 Could not be 2 Suicide 6 Could not be 2 Suicide 6 Could not be 2 Suicide 6 Could not be 2 Suicide 6 Could not be 3 Suicide 6 Suicide	vumber or Rural Route Number,				
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29a. Certifier (Check only one)  29a. Certifier (Check only one)  29b. Signature and title at certifier)  29c. License number  29c. License number  29d. Date 9	Number or Rural Route Number, and manner as stated. ace, and due to the cause(s) signed (Month, Day, Year)				

Teresa Mae Pearson-Smith

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

		I- For State Registrar			Certific	cate of	Death				Reg No	21	106	3461	
Physicia	an/	Decedent's Name (First, Middle,Last)  Teresa Pearson-Smith  2. Date of Death Month Day Year October 13, 2006  3. Time of Death 0933 hrs  4c. County of Death													
Medical Exami	ner					1.	- O: T	Logation O	f Dooth	Octobe	13, 20	006	f Dooth	0933 IIIS	_
		Paxtuxent River Nava				14	Patuxent		Dealii			St. Mary			
Funeral		Social Security Number	6. Sex		In yrs. last b	irthday)	If Under 1 Y		r 24Hrs.	8. Date of		M/DD/YYYY		place (State or	$\dashv$
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	ŀ	Usual Residence of Decedent													
у аву		10a. State 10b. County		1	c. City, Tow									0d. Inside City Limit	- 1
Maryland 28a-f show d at once.	ō	Maryland Calve	ert 		St. L	eonar					T			Yes 2 X N	.0
ie ie		10e. Street and Number 3060 Cage Road					10f. Zip Code <b>2</b> 0	685				itizen of Wh			
with the ms 23a		11. Marital Status		Decedent Ev	er in U.S.		Decedent of I				No-			n Indian, Black,	$\dashv$
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after	by F		vorced If Yes, Give or Dates:				Yes 2X					Specify:		ite	
5-0036 led within 72 hours after Hygiene. other than "natural", the Medical Examiner		15. Decedent's Education (Sp		grade comple e (1-4 or 5+)			s Usual Occup st of working I		kind of work done use retired) 16b. Kind of Business/Industry						
36 nin 72 e. than '	Completed	Elementary/Secondary (0-12)	Colleg	e (1-4 01 5+)		omema)	ker		own home						
d with	등	17. Father's Name (First, Middle	e, Last)					18.Mother's	s Name (	First, Middl	e, Maide			-	$\dashv$
21215-0036 uld be filed within 7 Mental Hygiene. marked other than e event, the Medica	Be (	Johnny Morr	is Pearso	on					er's Name (First, Middle, Maiden Surname)  Mae Stapleton						
b, MD 2121 and 2 should be fi lealth and Mental tem 27 is marked traumatic event,	ျ	19a. Informant's Name/Relation	,	. 7			Address (St						n, State, Z	ip Code)	
alt m alt		Harold W. Smith	1- nusbar	na			Cage Ro			nard,		20685 Location -	City or To	num State	_
	- 1		X Burial 2 Cremation 3 Removal from State crematory or other place)								16		•		
limore Pages I ment of H tant: If i		Donation 5 Other Specify: Southern Mellorial Gargers									ועון	unkirk	Mar	yland	_
Baltimore permit Pages I Department of I Important: If injury or other		Signature of Funeral Service Licensee  22. Name and Address of Facility Raus 4405 Broomes Ts Pr									usch Funeral Home				
Physician	-	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory									T RE	EDUDII	C MD	20676 Approximate Interve	al
/Medical		failure. List only one caus	e on each line.										3	Between Onset and Death	d
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it i	Examiner	events resulting in death) Last	Due to (or	as a consequ	uence of);		-						1		$\neg$
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	a		d												_
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Box 68 to death cert the attendir red for use a	icia	past 12 months?	4 Pi	regnant at tin	ne of death		er (Specify)				- 2				Į
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b.O. that the		Part II. Other significant cond	itions contributii	ng to death b	ut not result	ing in the ui	nderlying caus	e given in Pa	π ι.					oly 4 Unknown	
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Phys er this	ပ	1 Yes 2 No 27. Manner of Death	, r			o. Time of In		njury at Work				njury occurr		cene	$\dashv$
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Hosp 24 ho Fune			Physician: To the												$\neg$
To the Ho within 24 I To the Fu	Medical	one) 2 Medical Ex	aminer: On the ba and manr	sis of examir er stated.	nation and/o	r investigati	on, in my opin	ion, death oc	curred at	the time, d					╝
->	Ž	29b. Signature and title of certif	ier	1.0				ense number						n, Day, Year)	
		Maryno,	mello	ell			0.0	C.M.E.			00	ctober 14	, 2006		
2		30. Name and address of person	-				nn Straat	Baltimar	MD	1201					
3		Margarita Korell MD.		124			enn Street,	Daillillore	, IVID 2	1201					$\dashv$
S Regis	tate trar														

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene.

			1 - For State Registrar	State of M	aryland		artment of F rtificate of			giene 006	34610
	Physici	an	Decedent's Name (First, Middle,     Decedent's Name (First, M	•					2. Date of De		3. Time of Death
	/Medic Examir		Tung M  4a. Facility Name (If not institution, Saint Jose		nan	1	4b. City, Town, o	r Location of Deatl	h	4c. County of De	eath
					I Cer		If Under 1 Year	If Under 24 Hrs.	S O Ti 8. Date of Bir		altimore
	Funeral Director		217-94-3198	1 <b>X</b> M 2□F	46	Yrs.	Months Days	Hours Min.	June 6	ıy, Year)	Birthplace (State or Foreign Country) 7iet Nam
	land ow		Usual Residence of Decedent 10a. State 10b. County		10c. City,	, Town or La	cation				10d. Inside City Limits
	e Many	ctor	CA Oran	ge	We	estmin	ster				1 XYes 2 ☐ No
	with the or 28	Dire	10e. Street and Number 7750 Tenth Sti	ceet Apt. 3			10f. Zip Code	2683		10g. Citizen of What Viet Na	•
	ems 23	Funeral Director	11. Marital Status	12. Was Decedent	Ever in U.S	S. 13.	Was Decedent of H		pecify Yes or No		merican Indian,
50	be filed within 72 hours after death with the Maryland ntal tyglene. ad other than "natural", or items 23e or 28e-f show event, the Madical Examinational be natified at	by Fu	1 ☐ Never Married 2 ☑ Marrie 3 ☐ Widowed 4 ☐ Divorced				1 □ Yes 2 No	Specify:	5 7 HOZII, 6(6.)		Letnamese
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Z Z	s 1 and 2 should f Health and Mer item 27 is marke other treumatic		19a. Informant's Name/Relationsh  Ivy Le, Daught				ig Address <i>(Street)</i> lin Road			er, City or Town, State 9355	, Zip Code)
ore,	of Head of Head of Item		20a. Method of Disposition 1 □ Burial 2 ☑Cremation		20b. Pla		sition (Name of natory or other place		Date	20c. Location - City	or Town, State
Баппо	it. Pag rtment rtant: I		4 □ Donation 5 □ Other (Sp 21. Signature of Funeral Service L	ecify)	Pee		ematory			Westminst	
r D	permit. Pages 1 Department of H Important: If Ites any injury or ott		Pruser a	& Tell	ach					neral Home ngs, MD 20	
ı			23a. Part1. Enter the disease, or o shock, or heart failure. List of	complications that caused only one cause on each li	i the death. ne.						Approximate Interval Between
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cords	require een sig nould b	sted t	ADULT RESPIRATO		SYND	ROME			101	/es 2 No 3 □	Probably 4 Unknown
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	ien: T artificat ctor, pa	Be Co	25. Was case referred to medical examiner?	parties				26. Place of Dea	1  Yes	21 No 1 □ Ye	as No
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	or Atte	Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin		ury - At hom c. (Specify)	ne, farm, str	eet, factory, office		28f. Location (S City or Tov	Street and Number or i	Rural Route Number,
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	the Ho hin 24 the Fu mpletel	Medical	one) A Medical E	xaminer: On the basis o	examination	on and/or inv	estigation, in my op	oinion, death occur	rred at the time,	date and place, and d	ue to the cause(s)
	5 1 <u>k</u> 5		29b. Signature and little of certifier	3116	10 A	$\wedge$	29c. License	9 number 9453		29d. Date signed (Mo.	nth, Day, Year)
			30. Name and address of person w	tho completed cause of d	eath (Item 2	23a) (Type,				. 101	
	Sta	te.	LINDA F BARI 31. Date filed (Month, Day, Year)	R., M. D. 7	_		DRIVE	TOWSON	N, MARYL	AND 2120	4
	Registr			1 8 2006 > 6	Beller	K	Courtes				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 006 1 - For State Registrar Certificate of Death Reg. No. I. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Ellsworth POOLE Claude /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner real ahrne 8. Date of Birth Dec. 27, 1911 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** Months Days Hours 94 Maryland 1⊠M 2□F Director 214-09-0751 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State item 27 is marked other then "neturel", or items 23e or 28e-f show other treumatic event, the Modical Evant art must be notified at 1 ☐Yes 2X No Maryland Washington Hagerstown Director 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 21742 18847 Preston Road U.S.A. 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 2 should be filed within 72 hours after and Mental Hygiene. is marked other then "neturel", or Ite 1 ☐ Yes 2 🗗 If Yes, Give Year or Dates: 2 No 1 Never Married 2 Married Specify: white 1 ☐ Yes 2 No Specify: À 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) chief deputy clerk county government 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Harry Eugene Poole Anna May Byrum 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 sh Department of Health and Importent: If Item 27 is m eny injury or other treum <u>once.</u> Post Office Box 121, New Haven, New York Joan P. Waterbury - daughter 13121 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition October 1 Burial 2 □ Cremation 3 □ Removal from State Rest Haven Cemetery Hagerstown, Maryland 23, 2006 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Minnich Funeral Home 415 East Wilson Blvd., Hagerstown, Maryland 21740 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician neumonia disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Heart Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) use as the burial-tran physicien certificate be Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy The law requires that the death Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No jo 4☐Pregnant at time of death 5 Other (specify) ed by the a detached f 9 Unknown signed I 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Munknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s certificate has autopsy performed 1 Yes 2 No 252 No Hospitel or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No this After this 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of Certification: 1 SNatural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident d in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours at To the Funerel D completely filled i 15/Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D 12323 Deter 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 25H-5 1126 Opal Waspen 32. Registrar's 6ignature 31. Date filed (Month, Day, Year) State OCT 24 2006 Registrar

				State of M	aryland /	Depar Cert	tment of r ificate of	Health and r <i>Death</i>	vientai Hy	Reg. No.	006	3461	2
	Dhysisi	2.0	1. Decedent's Name (First, Middle,	Lest)					2. Date of De Month	eath Day	Year	3. Time of De	ath
	Physici /Medic			omans					Octob		2, 2006		p.m.
1	Examin	er	4a Facility Neme (If not institution,					4b. City, Town, or L		n 4c.	County of Dea	ath .gomery	
			Brooke Grove Fot  5. Social Security Number		ge (In yrs. lest	hirthday)	If Under 1 Year		Spring  8. Date of Bi	rth			oreian
	Funeral Director			5. Sex 7. Ag 1  M 2 □ F	92	Yrs.	Months Days	Hours Min.	8. Date of Bi (Month, Di Jan • 2	4, Υθ <i>αγ</i> )	914 18	rthplace (State or Fountry) Wa	
	and and	-	Usual Residence of Decedent  10a. State 10b. County		10c. City, To	own or Loca	ation					10d. Inside City I	Limits
	Mary fish	호	Maryland Fre	ederick		Mic	ddletowr	1				1 □ Yes 2	No No
	or 28s	Director	10e. Street and Number	-			10f. Zip Code			10g. Citi	zen of What C	ountry?	
	th wit	alD	8917 Gloria Ave	enue			21769				JSA		
020	permit. Pages 1 and 2 should be liled within 72 hours efter death with the Maryland Department of Health and Mental Hygiene.  Important: If tien 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be notified at once.	by Funeral	11. Marital Status  1 □ Never Married 2 □ Marrie  3 🌣 Widowed 4 □ Divorced	12. Was Decedent Armed Forces? d 1 □ Yes 2 ☑ If Yes, Give Year or Dates:			as Decedent of I Yes, specify Cub ☐ Yes 2 🙀 No	Hispanic Origin? (Spean, Mexican, Puerto Specify:	pecify Yes or No o Rican, etc.)		14. Race - Am Black, Wh Specify.Wh	ite, etc.	
2- -0	72 ho netur fical	eted	15. Decedent's (Specify only highest	Education grade completed)	16	6a. Decede (Give ki	nt's Usual Occup nd of work done	pation during most of wor	king	16b. Ki	nd of Busines	s/Industry	
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/lan	uld be 1 Aental I rked of tic eve	To Be	William Hilborn						ia Grac				
Mar	ind 2 sho alth and N 27 is ma or trauma		19a. Informant's Name/Relationshi James Robert Ro		1 8	9b. Mailing 89 <b>17</b> (	Address (Street Gloria	tand Number or Ru Avenue, M	ral Route Numb iddleto	wn, l	r Town, State, MD 2176	Zip Code) 59	
more	Pages 1 and of He not: If item iry or other		20a. Method of Disposition 1		ceme	etery, crema	tion (Name of atory or other pla ty Cemet	U	ct. 19, 2006		nroe.		
Balti	pemit. Departrimporta any inju		21. Signature of Funeral Service Li	Censee /	,			· Collins	Funera	1 Ho	me Inc		01
			23a. Part1. Enter the disease, or can shock, or heart failure. List o	omplications that cause	d the death. D	1						Approximate Interval Between	
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į.	/Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	a PNEL	MON	IA						3 WEEK	٠\$
a l		E.	resulting in death)		Due to (or as	a consequ	ence of):						
	tificate be executed g physician and as the buriel-transit	edical Examiner	Sequentially list conditions,	b	Due to (or as	a consequ	ence of):						
90,	be exe cian a ouriel-l	al Ex	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	C									
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Ď.	death e ette	icla	Part II. Other algnificant condition	s contributing to death t	out not resulting	g in the und	lerlying cause gi	ven in Part I.	23b. Did	tobacco	usa contribut	a to the causa of d	death?
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ń,	es tha	by									l (au	NA	
Division of Vital Records, P.O. Box	The law requires that the death certificate has been signed by the ettending page 2 should be detached for use as	Completed by Physiclan/M								an autop ormed?	sy 240	. Were autopsy find available prior to completion of caus of death?	-
Rec	2 5	dmc							10	Yes 24	ð.Nv	1 ☐ Yes 2 ☐ No	2
ta	in: The lifticate or, part	Be Co	25. Was case referred to medical					26. Place of Dea			ENTO	12 103 22 110	
$\leq$	ysicie s cert direct	To B	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpati	ent 2 ER/	Outpatient	3□ DOA Oti		- 10		S ZOther (Sp	ecity) ASSISTE	ED
0	Attending Physician: or death. ector: After this certific by the funeral director,	ü	27. Manner of Death 1   Natural 5 □ Pending	28a. Date of Inju (Month, Da		b. Time of Injury	28c. Inju Wo		28d. Describe	how injur	y occurred	LIUW	G
S	lendir leath. or: Al the fu	catio	2 Accident investigation in Suicide 6 Could no	ition				]Yes 2□No	006 1	/C4 4	al bloomban a na	Sum I Davida Aliumbai	
Ö.	ior Att efter d Direct 3 in by	ertifi	4 Homicide determin	ed   200. Flace of In	jury - At home, lc. <i>(Specify)</i>	, tarm, stree	et, factory, office		City or To			Rural Route Number	7,
	To the Hospital or Attending Physician: The li within Z4 hours effor death.  To the Funeral Director: After this certificate he completely filled in by the funeral director, page	edicai Certification:		Physician: To the best xaminer: On the basis of and manner st	f examination								
	Vithin To the comp	Me	29b. Signature and title of certifier				29c. Licen			29d. Dat	e signed (Mor	oth, Day, Yeer)	
	15		NEDOW.	e mo				3700		OCTO	BER 1	e, 2006	
			30. Name and address of person w	154 N	ARTI	CAAS		WILLI AMS	PORT.	MD	71	795	
	Sta	te	31. Date filed (Month, Day, Year)	3 Regist	rar's Signature	1	1. 1						
0	Registr	ar	OCT 17	2006 Keen	rar's Signature	14000							

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			For State Registrar	State of Mary	land / Depa <i>Cei</i>	artment of H tificate of L	lealth and Death		iene 2 () () ( eg. No.	5 34613
	Physicia		Decedent's Name (First, Middle, Las     COLIN STUART					2. Date of Dea Month	th Pay 86	3. Time of Death
	/Medic Examin	er	4a. Facility Name (If not institution, give Peninsula Reg I ONO)  5. Social Security Number 6. Se	street and number)  Medicol	Center yrs. last birthday)	4b. City, Town, or	Alisbury If Under 24 Hrs	8. Date of Birth	4c. County of Dea	MICO rthplace (State or Foreign
	Funeral Director			2 M 2 □ F 69	Yrs.	Months Days	Hours Min	APR. 3,	1937 I	ENGLAND  10d. Inside City Limits
:	permit. Pages 1 and 2 should be filled within 2 hours aret death with the maryland Department of Health and Mential Hydrach Innocrant: if them 27 is marked other then "natural", or items 23a or 28e-1 show eny injury or other traumatic event, the Medical Examinar must be notified at once.	al Director	VA ACCOMACE  10e. Street and Number  29495 QUAIL CIRCLE		IELSONIA	10f. Zip Code 23414	•	1	0g. Citizen of What C	1 ☐ Yes 2 No
950	rel', or items?	d by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 ሺ Widowed 4 □ Divorced	12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates:		Was Decedent of H f Yes, specify Cuba 1 ☐ Yes 2√ No	ispanic Origin? ( In, Mexican, Pue Specify:	Specify Yes or No- no Rican, etc.)		ite, etc. NHITE
7-61212	o within 72 m glane. er then "natu	Completed	15. Decedent's Ed (Specify only highest grades) Elementary/Secondary (0-12)		(Give	dent's Usual Occup kind of work done of DO NOT use retired NGINEER	during most of wo		POULTRY II	
yair	ould be file Mental Hy varked oth vatic event	To Be (	17. Father's Name (First, Middle, Last)  GEORGE STUART RUN		1.01.11		OLIVE	MARY WIND	LEY	T- 0-4)
e, Mar	l and 2 sn lealth and im 27 le m her traum		19a. Informant's Name/Relationship (7 PAM DOOLING (STEP	DAUGHTER)		PAYNE RO		COMOKE, N	r, City or Town, State, D 21851  20c. Location - City of	
Saltimor	t. Pages tment of H tant: if its jury or ot		20a. Method of Disposition  1 Burial 2 Termation 3 4 Donation 5 Other (Specify	Removaf from State	Cemetery, crer	REMATOR OF STREET	ORY OCT	20, 2006	EXMORE,	VA
0	Depar Impor		21. Signature of Funeral Service Licental  CARL U. THO	ORNTON		ADBOURNE	ST PA	FUNERAL HOLARKSLEY, V.		
•	Cate be executed by Sician and but sician and the prijal-transit the prijal-transit street by Sician and Sicia	dical Examiner	shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	one cause on each fine.	onsequence of):	intery .				Interval Between Onset and Death
O. BOX 08	death certifi e attending id for use as	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of p 1 □ Live birth 2 □ 4 □ Pregnant at time 9 □ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)	,		23d. Date of d Month	elivery Day Year
ras, r.	requires that the een signed by th hould be detache	Ď	Part If. Other significant conditions o	ontributing to death but no	ot resulting in the u	nderlying cause giv	en in Part I.			to the cause of death?  Probably 4 Unknown
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ion of Vital	To the Hospital or Attending Physician: To the Funarel Director: After this certific completely filled in by the funeral director,	ation: To Be	25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending 2 Accident rivestigation		2 ER/Outpatier 28b. Time o Injury	f 28c. Injur Wor	er: 4 ☐ Nursing		ence 6 □Other (Sp ow injury occurred	necity)
DIVISION	oital or Atteurs after de irei Directo	Certification:	3 Suicide 6 Could not be determined	building, etc. (S	Specify)			City or Tow		
	the Hosp thin 24 hosp the Funa empletely fi	Medical		ysician: To the best of m niner: On the basis of exa and manner stated	amination and/or in		pinion, death oc	curred at the time, o		ue to the cause(s)
	F B F S		30. Name and address of person who	completed cause of death	) (film) 23a) (Tyne	D 4	6536	01 1	10/16/0	76
	Sta	ate	100 E amul  31. Date filed (Month, Day, Year)	32. Registrar's	renins	In Keg	nonel	Medica	e cent	k

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Year 1:40 P M October 2006 14, Schlafstein Rachmill 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Montgomery Bethesda Suburban Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 1 XM 2 ☐ F Yrs. 6-22-1928 Brazí1 230-30-9738 78 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County Potomac 1 Yes 2 No Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20854 U.S.A. 10001 Gainsborough Rd. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 ☐ Yes 2 ☒ No Specify: Specify: White 3 Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 5+ Pharmacist Medicine 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Jacob Schlafstein Sosia Kogod 19a. Informant's Name/Relationship (Type, Print) Beverly A. Schlafstein/ Wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10001 Gainsborough Rd. Potomac, MD 20854 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ⊠ Burial 2 □ Cremation 3 □ Removal from State Olney, MD 10-16-06 Judean Memorial 4 □Donation 5 □ Other (Specify) 21. Signature of Furieral Service Licensee 22. Name and Address of FacilityEdward Sagel Funeral Direction 1091 Rockville Pike Rockville, MD 20852 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CARTOPUMWAN disease or condition resulting in death) IN M-CUMEAL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) ATRIA resulting in death) Last Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Year Month 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Impatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3□ DOA

**Physician** /Medical Examiner

Depertment o Important: If any injury or once.

Physician

/Medical

Examiner

10a. State

MD

**Funeral** 

Director

r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at

n 27 is marked other than "vitraumatic even"

.. Pages 1 and 2 should be fill tment of Health and Mental H tent: If Item 27 is marked oth jury or other traumatic even

72 hours efter death

within 7

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Baltimore,

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Director

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δ Completed

To the Hospital or Attending within 24 hours after death.
To the Funeral Director: After completely filled in by

Be

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Certification:

IF FEMALE: 23b. Was decedent pregnant

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

1 Yes 2 →No 27. Manner of Death

1 Natural

2 Accident

3 Suicide

4 - Homicide

5 Pending 6 Could not be determined

28a. Date of Injury (Month, Day Year) investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of Injury

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

M 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

8600 w

GONGOTOWN NO

State Registrar 31. Date filed (Month, Day, Year) 17



			For	State of Maryland /	Department of Health and N	Mental Hygie	ne o o c	01616
			1 - State Registrar		Certificate of Death	Reg.	NO. UU6	34615
	Physic	an	1. Decedent's Name (First, Middle, L	A 0	alc	Date of Death     Month	Day Year	3. Time of Death
	/Medi	cal	4a. Facility Name (If not institution, g	DHR OCHM		OCLOP RA	11 2006	
1	Exami	ner	Si Vay Hosoid	Al of Baltimen	4b. City, Town, or Location of Death	itu	4c. County of Death	MARE
	Funeral			Sex / 7. Age (In yrs. last bi	rthday) If Under 1 Year If Under 24 Hrs.	8. Date of Birth	9. Birth	place (State or Foreign
Н	Director		084-05-3896	10 M 2 V F 103	Yrs. Months Days Hours Min.	Month, Day, Ye	1902 Cou	place (State or Foreign
	and		Usual Residence of Decedent  10a, State 10b, County	10c. City, Tow	or Location			
	Maryli f sho	ō	MD CARD	INF DOE	STON			10d. Inside City Limits 1 ☑ Yes 2 ☐ No
	h the Marylan r 28a-f show	rect	10e. Street and Number	-1100 1100	10f. Zip Code	10a	Citizen of What Cou	
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	s after death with or Items 23a or	Funeral Director	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	pecify Yes or No-	14. Race - Ameri	
36	s afte	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ No If Yes, Give	1 Yes 2 No Specify:	ricari, etc.)	Black, White,	etc.
5-0036	r 72 hours after death with the Maryland "neturel", or Items 23a or 28a-f show idical Examinat must be mulfiled at	ed b	15. Decedent's 1	Year or Dates:		11	Wi	7110
15	C 2	Completed	(Specify only highest g	rade completed)	Decedent's Usual Occupation     (Give kind of work done during most of work life. DO NOT use retired)	ding 166	. Kind of Business/In	ndustry
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р	be filed ital Hygid od other event, t	Be	17. Father's Name (First, Middle, Las		18. Mother's Nam	e (First, Middle, Maid	den Sumame)	A =
<u>\S</u>	2 should be filed within and Mental Hygiene. Is marked other than eumetic event, the Mental Annelic event, the Mental Annelic event, the Mental Annelic event.	Ç	GEURGE FRA	NKLIN FLOHK	200100	JANE	REYN	IOLDS
Maryland	d2st thanc 7 Is n treun		19a. Informant's Name/Relationship	(Type, Print) 19t	Mailing Address (Street and Number or Rur	0010.	ty or Town, State, Zip	Code)
	of Health of Health item 27 I		20a. Method of Disposition	20b. Place o	f Disposition (Name of	ISH CTITY OF	Location - City or To	21ZOI
آ ا	Sages ent of nt: If it ry or o		1 Burial 2 □ Cremation 3   '4 □ Donation 5 □ Other (Spec	☐Removal from State   cemete	ry, crematory or other place)	4 06 D	OFZIDA)	LIN State
Baltimore,	permit. Pages 1 and 2 should Department of Health and Men Importent: If item 27 Is marke eny injury or other treumetic onge.	25	21. Signature of Funeral Service Lice		22. Name and Address of Facility	000 17	(0)100	,1910
ä	permi Depa Impo eny ir				22 Name and Address of Facility UE	NED ALSO	BURG, MC	02/1632
•			23a. Part1. Enter the disease, or cor shock, or heart failure. List only	nplications that caused the death. Do	not enter the mode of dying, such as cardiac	or respiratory arrest,	2012/11/6	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	. Acute My	ocardial Infaction	~		Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequence				, , ,
Н		ē	Sequentially list conditions,	b. Due to (or as a consequence	distress with h	ypoxiA		1 day
	uted d ansit	min	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Spocis	o.,.	1.		1 day
o,	exec an and rial-tra	Examin	that initiated events resulting in death) Last	Due to (or s a consequence	of);			1 3009
68760,	flicate be executed g physician and ts the burial-transit	edlcal		d				
	= D m	Med	IF FEMALE:					
Вох	death certifi e attending id for use as	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death			23d. Date of delive	
0	0 00	Physician/M	1 ☐ Yes 2 No 9 ☐ Unknows	4☐Pregnant at time of death 9☐Unknown	5 Other (specify)		Month	Day Year
<u>α</u>	w requires that the de been signed by the should be detached	/Ph	Part II. Other significant conditions	contributing to death but not resulting in	the underlying cause given in Part I.	23e. Did tobacci	o use contribute to the	ne cause of death?
rds	quires n sigr ald be	d by		Ascular Acciden	<u> </u>	111		ably 4 □Unknown
Records,	The law requires that the site has been signed by the bage 2 should be detache	Completed	Hupertensi	00.		24a. Was an	24h Were auto	psy findings available
æ	ysicien: The lav is certificate has director, page 2	mo	Dans & A			autopsy performed?	prior to cor death?	npletion of cause of
ita	icien: Th certificate rector, pag	BeC	25. Was case referred to medical examiner?		26. Place of Death	1 Yes 2 1	No 1 ☐ Yes	2/No
of Vital		2	1 ☐ Yes 20€No	Hospital: 1 Inpatient 2 ☐ ER/Ou	Other		6 ☐Other (Specify	')
	ling P	on:	27. Manner of Death  1 Natural 5 ☐ Pending	(Month, Day Year) In	ime of 28c. Injury at 28cr. Work?	28d. Describe how in	jury occurred	
Division	I or Attendi after death. Director: A I in by the fu	Icat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be		M 1 Yes 2 No			
D.	after Direction by	Certification:	4 Homicide determined	28e. Place of Injury - At home, far building, etc. (Specify)	m, street, ractory, office	City or Town, Sta	and Number or Rura ate)	l Route Number,
	To the Hospitel or Attending Phwithin 24 hours after death. To the Funerel Director: After th completely filled in by the funeral		29a. Certifier Certifying Pl	nysician To the best of my knowledge	, death occurred at the time, date and place, a	and due to the cause	(s) and manner as st	ated
	he Ho in 24 he Fu pletel	Medical	(Check only 2 Medical Exer	inner. On the basis of examination and	Vor investigation, in my opinion, death occurre	ed at the time, date a	ind place, and due to	the cause(s)
	To T To t	2	29b. Signature and title of certifier	16/	29c. License number	29d. D	Date signed (Month, L	Day, Year)
•			- Com-	The	19438	Oct	ober 11.	2006
				completed cause of death (Item 23a) (	Type, Print)	0 111	0	
	Sta	6	31. Date filed (Month, Day, Year)	32 Registrar's Signature	sircu Hospital at	Douthin	inc	
	Registra	_	OCT 1 6 20	06 Brance St	29c. License number 19438  Type, Print) Sinci Hospital of			
				19				

Patheut Known As: Julia Schnick

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 06 Reg. No. U Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 9:15 P M Sorr /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Grasonville Queen Anne's Cemetery Road If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days 1 M 2 F Months Hours Yrs 7-30-9978 NOV. 14, Director Maryland Usual Residence of Decedent 72 hours after deeth with the Maryland 10b County 10c. City, Town or Location 10d. Inside City Limits 10a State or 28a-f shov trsumetic event, the Medical Examiner must be notified at 1 Yes 2 No Queen Anne's Completed by Funeral Director MD Grasonville 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number .emetery 21638 USA itsms 23a 62 Road Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Yes 2 No ö 1 Yes 20 No Specify: If Yes, Give Year or Dates: Specify 3 Widowed 4 Divorced Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Food Processing Seasonal Food Helper 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Maryland To Be Pages 1 and 2 should be to nent of Health and Mental | snt: if Itam 27 is marked o JOHNSON Richard Sorrell Rosie 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 627- Cemetery Road Grasonville MD, 21638

Date 20c. Location - City or Town, State Natalle other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages 1
Department of H
Important: if Ita
sny injury or ot 1 Burial 2 Cremation 3 Removal from State Robinson's Cemetery 10/21/06 Grasonville, 4 ☐ Donation 5 ☐ Other (Specify) 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximate

Approximate

Approximate

Approximate

Approximate Immediate Cause (Final **Physician** CAPDIOM VODA disease or condition resulting in death) /Medical Due to (or as a consequence of); Examiner 168/106 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). Examiner 11AB613 attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760, ANOM Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 20 No
9 Unknown Year Month Day 4☐ Pregnant at time of death 5 Other (specify) P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy performed 2 X No 1 Yes After this certific funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 1 Natural Injury 5 Pending within 24 hours after death.

To the Funers! Director: All completely filled in by the fu 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide 12 Certifying Physiciam To the best of my knowledge death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 235 Cunfiller Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar Date filed (Month, Day

204 MULL et R

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2006

D27055

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			State of Maryland / De State of Maryland / C	partment of Health ar ertificate of Death		ene 006	34617
ı	Physici		1. Decedent's Name (First, Middle, Last)  Martee Elizabeth Thomas Thompkins		2. Date of Death Month	Day Year /2 2006	3. Time of Death 3:49 pm
	/Medic Examin		4a. Facility Name (If not institution, give street and number)  Doctor's Community Hospital	4b. City, Town, or Location of Lanham		4c. County of Death Prince Ge	1
	Funeral Director		5. Social Security Number 579-18-6920 6. Sex 1 □ M 2 ☎ F 89 Yrs	Months Days Hours	Hrs. 8. Date of Birth (Month, Day, Aug. 8,	Year) 9. Birth Col	nplace (State or Foreign Intry) ginia
20	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: if item 27 is marked other than "neturel", or items 23a or 28e-f show any injury or other treumetic event, its Medical Evanise must be notified at once.	by Funeral Director	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2X No			Og. Citizen of What Co United Sta 14. Race - Amer Black, White Specify: B.	tes ican Indian,
21213-0030	ad within 72 hours giene. er than "neturel" i, Ire Mudical Evi	Completed b	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  Hot	cedent's Usual Occupation ve kind of work done during most o a. DO NOT use retired) use keeper	of working	Domestic	ndustry
yland	uld be file Mental Hy arked oth	To Be (	17. Father's Name (First, Middle, Last) Richard Thomas	01iv	s Name (First, Middle, M ia Smith		
, mar	and 2 sho baith and n 27 is mu		Stephanie P. Thompkins (daughter)		Upper Marl	boro, MD	20774
Imore,	Pages 1 ment of He ent: If iter ury or oth		cemetery,	sposition (Name of trematory or other place) ncoln Cemetery	10/23/06 B	rentwood,	MD
ned A	permit. Departr Importe any init		21. Signature of Fineral Service Licensee	22. Name and Address of Facility 7400 Georgia Av			ce 20012
1,000	Description of the property of	Ical Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):		ardiac or respiratory arre		Approximate Interval Between Onset and Death
O. Box 68	death certific e attending p id for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 menths? 1 □ Yes 2 ☑ No 9 □ Unknown  23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of deli Month	very Day Year
2	juires that n signed b	by	Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause given in Part I.		acco use contribute to	the cause of death?
Records,	The law requires that the sate has been signed by the page 2 should be detache	Completed			24a. Was ar autops perform	y prior to death?	topsy findings available completion of cause of
<u> </u>		O	25. Was case referred to medical	26. Place	of Death (Check only on		
o	Phys	lon: To B	27. Manner of Death 1 1 Deatral 5 Pending 28a. Date of Injury (Month, Day Year) 1 Inju	e of 28c. Injury at	sing Home 5 Reside		city)
DIVISION	Atten er deat ector: by the	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm building, etc. (Specify)			reet and Number or Ru , State)	ral Route Number,
	To the Hospitel or within 24 hours after To the Funerel Directions of the Completely filled in	Medical C	29a. Certifier (Check only one)  1 Certifying Physicien: To the best of my knowledge, described by the control of the dasis of examination and/cand manner stated.				
	To to to to to to to to to to to to to to	Σ	29b. Signature and tittle of certifier		_	Od. Date signed (Month	
			30. Name and address of person who completed cause of death (Item 23a) (Ty Cecil D. George, M.D. 7527 Greenwa	pe,Print) Ly Center Dr., (	Greenhel+ 1	MD 20770	
4.	St	ate	CO Desistando Signatura		or composited 1	20110	
DI-	Regist	5- <sub>10</sub> .	OCT 17 2006				

DHMH 17 Rev 1/2001

			For State Registrar	State of Maryl		Departme Certifica			and M	-	Reg. No	( U U D )	34618
	Physicia	an	1. Decedent's Name (First, Middle, Last Ivan Tempchin	)						2. Date of Dea Month Oct. 11	ath Da	2006 Yeer	3. Time of Death 2:45 Рм
	/Medic Examin		4a. Facility Name (If not institution, give 3100 N. Leisure W	street and number)	227	4b. Cit	y, Town, or 1ver	Location of Sprin	ıg		40 M	c. County of Death	У
	Funeral Director		3/9-34-2403	x 7. Age (In 7. 7. 7. 7. 7. 7. 7. 7. 7. 7. 7. 7. 7.		thday) If Und Month	er 1 Year s Days	If Under Hours	24 Hrs. Min.	8. Date of Birt Month Oa 11-30-1	<sup>h</sup> <sup>Y</sup> 28	9. Birth Cou Wash	place (State or Foreign ntry) ington, DC
	aryland ehow		Usual Residence of Decedent  10a. State 10b. County  Manufacture of Decedent			n or Location							10d. Inside City Limits 1   Yes 2   No
	th the M or 28a-f	Directo	MD Montgon  10e. Street and Number			1	Zip Code				-	itizen of What Cou	intry?
	ns 23s	eral	3100 N. Leisure W	12. Was Decedent Ever		13. Was Dec	20906 pedent of Hi	ispanic Ori	gin? (Spe	cify Yes or No	Մ.S	14. Race - Amer Black, White	
036	72 hours after death with the Maryland Insturet, or Items 23s or 28s-f show Arcal Examiner must be nutified.	by Fur	1 ☐ Never Married 2 🗷 Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:				Specity:		Rican, etc.)		Specify: Whi	
21215-0036	be filed within 72 hours after death with the Marylan Hydjene.  do other than "natural", or items 23s or 28s-f show event. Ite Marcical Examinar must be natified at	Completed by Funeral Director	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)		16a.	Decedent's Use (Give kind of life. DO NOT Accoun	work done o use retired	ation during mos d)	t of worki	ng	16b. l	Kind of Business/li Privat	
1d 21	e filed w Il Hygier other th	Be Cor	17. Father's Name (First, Middle, Last)	41		necoun		18. Mothe	er's Name	(First, Middle	Maide	n Sumame)	
Maryland	should be find Mental I	To E	Abraham Tempchin		19b	o. Mailing Addre	ss (Street			Shapin Il Route Numb		or Town, State, Z	ip Code) 20906
, Ma	tra tra		Edith Tempchin -	Wife		3100 N.	Leis	sure V	Vor1d	Blvd.	#22	27 Silver	Spring,MD
Baltimore,	permit. Pages 1 and Depirtment of Heeli Important: If Item 2 any Injury or other 2005.		20a. Method of Disposition  1   Burial 2 □ Cremation 3 □  4 □ Donation 5 □ Other (Specify	Removal from State	cemete	f Disposition (f ry, crematory o ebanon	r other plac		10-13	-06	Adel	Lphi, MD	
Ba	Departition of the control of the co		21. Signature of Funeral Service Licen			1170	Rockv	7ille	Pike	Rockv	ille	tal Chape , MD 208	
	Physician		23a. Part1. Enter the disease, or comp shock, or heart failure. List only Immediate Cause (Final disease or condition	olications that caused the one cause on each line.  Metastati							rrest,		Approximate Interval Between Onset and Death  16 Months
	/Medical Examiner		resulting in death)	Due to (or as a co									
	uted	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a co	rsequence	of):							
8760,	sate be executed ohysicien and the burial-transit		resulting in death) Last	Due to (or as a co	nsequence	of):							
.O. Box 68	death certific e ettending p od for use es	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pr 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death	n 3⊟Ectopi 5⊟ Other		у			/	23d. Date of deli Month	very Day Year
Ω.	uires that t signed by Id be deta	٤	Part II. Other significant conditions of Hypertension	ontributing to death but no	t resulting i	in the underlyin	g cause grv	ven in Part	1.	1			the cause of death?
Records,	The law requires that the sete has been signed by the page 2 should be detache.	Completed					<u></u>			24a. Was auto perfe 1 Yes		death?	topsy findings available completion of cause of
Vital	Physician: Th this certificete ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:	• C 5 5 6		DOA OU			h (Check only		6 □Other (Spec	264
ō	ding h. After fune	tlon: To	1 Yes 2 XNo  27. Manner of Death 1 XNatural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Ye	2 ER/O 28b.	Time of Injury	28c. Injui	4 🗆 14		28d. Describe			<i>-119)</i>
Division	of or Attending effer death. I Director: Afte d in by the fune	Certification:	3 Suicide 6 Could not b 4 Homicide determined	28e. Place of Injury building, etc. (S		arm, street, fac	tory, office			28f. Location City or To			ural Route Number,
	To the Hospitel or within 24 hours effer To the Funeral Director completely filled in	edical C	23a. Certifier 1 Z Certifying Pt (Check only one)	niner: On the best of m and manner stated	y knowledg imination a	ja Jaath Sonur nd/or investiga	rad at the ti tion, in my o	ima, date a opinion, de	nd place ath occur	and due to the red at the time	date a	(s) and manner as and place, and due	stated to the cause(s)
	To th within To th	Me	29b. Signature and title of certifier	1			29c. Licens					Date signed (Mont	
	7		30. Name and address of person who	completed cause of death	(Item 23a)	) (Type, Print)	כנע	5996		Į	1(	0/12/2006	
_			Linda M. Burrell	, MD 2730 Un	ivers 	ity Blo		00 Whe	eator	, MD 20	0902	2	
	St Regist	ate rar	31. Date filed (Month, Day, Year)  OCT 17 2	32 Registrar's	Signature	Specific							

	•	For State Registrar	State	of Maryla		rtment of He tificate of D			jiene 10g. No.	06	34619
		1. Decedent's Name (First, Middle, La	-					2. Date of Dea Month	ith Day	Year	3. Time of Death
Physicia Medic/					a Thom				13, 200		0210 <sup>M</sup>
Examin	er	4a. Facility Name (If not institution, gi Calvert Me				4b. City, Town, or L	ocation of Dea ce Frederi		4c. Cou	inty of Death Cal	vert
C			Sex		s. last birthday)	If Under 1 Year	If Under 24 Hr.	S R Date of Birth	7	9. Birtho	place (State or Foreign
Funeral Director			1□M 2 <b>X</b> )F	66	Yrs.	Months Days	Hours Min	(Month, Day Apr 2,		Cour	Maryland
P		Usuaf Residence of Decedent		100.0	City, Town or Lo	nation					10d. Inside City Limits
ehow	7	10a. State 10b. County  MD Ca	lvert	100.0	nty, rown or Lo		nce Freder	ick			1 ☐ Yes 2 🕱 No
the M 28a-f	Director	10e. Street and Number				10f. Zip Code			10g. Citizen	of What Cour	ntry?
3a or		260 Fairground Road					20678			U.S.A	۸.
iurs after death with the Maryle ali, or itama 23a or 28a-1 ehov Ever il et must be nettlische	Funerai	11. Marital Status	12. Was Dec	pedent Ever in	U.S. 13. V	Vas Decedent of His Yes, specify Cuban	panic Origin? (	Specify Yes or No-		Race - Americ	
or its		1 Never Married 2 Married	1 □Yes If Yes, G	2 <b>X</b> No ive		- 1	Specify:	,,	İ	city: Black	
hours urai',	d by	3 Widowed 4 □ Divorced  15. Decedent's E	Year or I	Dates:	16a Decer	lent's Usual Occupat	ion			f Business/In	
in 72 in 72 in all	piete	(Specify only highest g	rade completed		(Give	kind of work done du DO NOT use retired)	ring most of w	orking	100. 11114 0	, , , , , , , , , , , , , , , , , , , ,	,
d with giene.	Completed	Elementary/Secondary (0-12)	College	(1-4or 5+)		Ch	ef			Restau	rant
be filed within 72 hours after death with the Marylend be filed within 72 hours after death with the Marylend of other than "natural; or items 23s or 28s-f show event, it a Madical Ever it at mant be notified."	BeC	17. Father's Name (First, Middle, Las				1	18. Mother's Na	ime (First, Middle,			
12 should be filled within h and Mental Hygiene. 7 is marked other than " fraumatic event, it a Ma.	1º		Joseph	I. Tyler				-	tta Cha		0-41
12 sh h and 7 is m traum		19a. Informant's Name/Relationship Lisa Thomas-W	. / /	on Have		g Address (Street ar			r, City or For	wn, State, Zip	) (-00e)
permit. Pages 1 and 2 should be Department of Heelin and 2 should be Important: If item 27 is marked any injury or other traumatic events.		20a. Method of Disposition	1000 II POJE		Z* Place of Dispo	sition (Name of		Date	20c. Location	on - City or To	own, State
Pages nent of I int: if its		tX Burial 2 ☐ Cremation 3  4 ☐ Donation 5 ☐ Other (Spec		State	, .	natory or other place, s Cemetery	1	0/20/06	F	luntingto	wn, MD
permit. F Departmi Importar any Injui		21. Signature of Funeral Service Lice				Name and Address Sewell Fur	of Facility				
		Gladys a.	Serve	ll				oad Prince F	rederick	MD 206	78
		23a. Part1. Enter the disease, or conshock, or heart failure. List only	y one cause on	each line.	*	er the mode of dying,	such as cardia	ac or respiratory are	rest,		Approximate Interval Between Onset and Death
Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	_ a	(or as a conse						-	
Examiner			Due to	renal	E C	ilure.	m	ostiti	2		
1.0	ner	Sequentially list conditions, if any, leading to immediate cause. Little Underlying Cause (Disease or injury that initiated events	b. Due to	(or as a conse		-	)				
ecuted nd transi	Examiner	Cause (Disease or injury that initiated events	C	7/0 -						- 0	
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physic the k	dical	_	d							-	
eath certific ettending p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant		utcome of preg			170		23d.	Date of delive	ery
death e etter	iciar	in the past 12 months?	4☐Preg	birth 2□Fe  nant at time of		Ectopic pregnancy Other <i>(specify)</i>	NIA			Month	Day Year
at the by the tache	hys	9 Unknown	9□ Unk								
v requires that the de been signed by the should be detached	by	Part II. Other significant conditions	contributing to	death but not re	esulting in the u	nderlying cause giver	in Part I.	23e. Did to			he cause of death?
requir een s	sted	// /	3110								
e law has b	Completed							24a. Was autop	sv	lb. Were auto prior to co death?	ppsy findings available impletion of cause of
ician: The certificate rector, pag							00 Di (D	1 □ Yes \	2E No	1 Tes	2 No
Physician: The this certificate hiral director, page	o Be	25. Was case referred to medical examiner?  1  Yes 2 No	Hospital:	Inpatient 2	☐ ER/Outpatien	Other		eath (Check only or Home 5 Resid		Other (Specia	(v)
9 Phy er this		27. Manner of Death	28a. Date		28b. Time of Injury		at	28d. Describe h			77
ath. r: Aft	atio	Natural 5 Pending 2 Accident investigati	on I	nin, buy rour	injury		es 2 No				
To the Hospitel or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funerie Infector: After this certificate has been signed by the ettending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	ertification;	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	d 286 Plac	e of Injury - At ding, etc. (Spec		eet, factory, office		28f. Location (S City or Tow		mber or Rura	al Route Number,
urs af	O	CO. C. William V. A. C. C. William V.	husisian To th	boot of mule	naudadaa daath	and the tree	data and plac	and due to the	has (a)cause	manner as s	tatad
Hosp 24 ho Fune stely f	Medical	29a. Certifier Certifying F (Check only 2 Medical Exi-	aminer: On the	ie dest of my ki basis of examii nner stated.	nation and/or in	n occurred at the time vestigation, in my opi	nion, death occ	curred at the time, of	late and plac	e, and due to	o the cause(s)
Vithin Fo the	Me	29b. Signature and title of certifier				29c. License			-	ned (Month,	* * * * * * * * * * * * * * * * * * * *
->-0		> N. Mer	01000			0000	6063	8	10/13	310E	
3		30. Name and address of person wh NAYANTARA NEN. 31. Date filed (Month, Day, Year)	DON (A	use of death (It	em 23a) (Type,	Print) 110	HOSP.	iche R	oad 4D o	#3	8.
Sta		31. Date filed (Month, Day, Year)	32.	Registre's Sig	nature /K	Charles					
Registr	ar	UCI	L Y CHOO	1 JUGAR	W. JU.	Jahra or					

			For State Registrar	State of	of Maryland / Dep Ce	artment of Hea		Hygiene 006	34620
	Di		1. Decedent's Name (First, Middle	, Last)			2. Date of	Death	3. Time of Death
	Physici /Medio		Albert Lu	ther Tu	rner		OCTUB	Day Ye ER 17. 20û	
	Examir		4a. Fecility Name (If not institution			4b. City, Town, or Loc		4c. County of D	
			Reeder's Me				sboro		shington
	Funeral Director		5. Social Security Number 214-14-6341	6. Sex 1 🖾 M 2 🗆 F	7. Age (In yrs. last birthday) OO Yrs.			Birth 9.	Birthplace (State or Foreign Country)
			Usuel Residence of Decedent		90 Yrs.		Jan.	16, 1916	Maryland
	arylanc ehow		10a. State 10b. County		10c. City, Town or L	ocation			10d. Inside City Limits
7	Ba-f-	ctor	Maryland Wash	ington	Ha	gerstown			1 ☐ Yes XXNo
1-	ith th	Director	10e. Street and Number			10f. Zip Code		10g. Citizen of What	: Country?
45	e 23e		18317 Collec				740		SA
4	ter de	by Funeral	11. Marital Status  1 ☐ Never Married 2 ☐ Marri	Armed Fo	edent Ever in U.S. orces? 13.	Was Decedent of Hispar If Yes, specify Cuban, M	nic Origin? (Specify Yes or lexican, Puerto Rican, etc.)	No- 14. Race - A Black, W	merican Indian, /hite, etc.
五岁	hours after death with the Maryland uret', or Iteme 23e or 28e-f ehow at Examiner must be nutified at	by F	3 Widowed 4 Divorced	If Yes, Gr	ve	1 ☐ Yes 2 ☒ No Sp	pecify:	Specify:	1.0 • 1
A 9	72 ho	Completed	15. Decedent	s Education	16a. Dece	dent's Usual Occupation		16b. Kind of Busine	White
X 2	within 72 ene. than "na	nple	(Specify only highes Elementary/Secondary (0-12)	College (	lite	kind of work done during DO NOT use retired)	g most of working		
1 ≥ 1 ≤	led w lygier her th	ပိ	8	1		Packer			anufacturer
300	ntei H ed of	Be	17. Father's Name (First, Middle, L Charles W. T	urner		18.	Mother's Name (First, Mide Ora Anna F	dle, Maiden Sumame) Reeder	
TURNER, AL Maryland 21215-0036	should ad Me mark matic	ြ	19a. Informant's Name/Relationsh		10h Maili	ng Address (Street and A	Ora Anna I		
, E	nd 2 :		Richard L. Tur	1768	1 OS4504				
WAM E Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Depertment of Health and Mentel Hygiene. Inportent: if Item 27 is marked other than "naturel", or Items 23s or 28s-1 show any Injury or other traumatic event, the Medical Examinar must be nuffied at once.		20a. Method of Disposition		20b. Place of Dispo	osition (Name of matory or other place)	e Rd. Boonsbo	20c. Location - City	
ZE	Page nent c		1 🖾 Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp		State		Oct.20,2006	Sharnshur	Maryland
A H	permit. Depentr Import any Inju		21. Sonal 19. of Fund 11 Service 1	ice see			Fairy Home, P./		21795
	207 2 9		Cant Co				ocheague St.		rt, Maryland
			23a. Part1. Enter the disease, or o shock, or heart failure. List of	complications that only one cause on e	caused the death. Do not enterach line.	er the mode of dying, su	ch as cardiac or respiratory	arrest,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)	a	Pneumon	119			Onset and Death
	/Medical Examiner		rosaking in dodati,	Due to	(or as a consequence of):	Canada	·		
	¥	Je.	figure tally list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b Due to	(or s a consequence of):	Cance	.у		years
	orted ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	2					•
ó	be executed icien and burial-transit	Ex	resulting in death) Last	Due to	(or as a consequence of):				
8760,	cate be executed physicien and the burial-transii	dlcal	1	d					
9	as a	•	IF FEMALE:	22- 14					
Bo	eath certif attending for use a	cian	23b. Was decedent pregnant in the past 12 months?	1□Live b	come of pregnancy birth 2 ☐ Fetal death 3 ☐ lant at time of death 5 ☐	Ectopic pregnancy		23d. Date of o	delivery Day Year
o.	at the de by the tached	Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unkno		Other (specify)			,
Division of Vital Records, P.O. Box	Attending Physicien: The law requires that the death certific redath. ector: Atter this certificete has been signed by the attending toy the funeral director, page 2 should be detached for use as		Part II. Other significant condition	s contributing to de	eath but not resulting in the u	nderlying cause given in I	Part I. 23e. Did	d tobacco use contribute	to the cause of death?
ž	v require been sig should b	edt	C5	onary	avery &	neane. Itus	1	]Yes 27€No 3□	Probably 4 Unknown
မ	has be	plet	$\mathbb{Z}$	rabete	se mill	itus	24a. W	as an 24b. Were	autopsy findings available
<u>~</u>	r. The	Completed by		1d as	e.		pe 1 ☐ Yes	formed? prior t death:	o completion of cause of ? es 2□ No
Vita	uician: certitic rector,	Be	25. Was case referred to medicat examiner?	0		26.	Place of Death (Check only		
to	Phys this ral dir	5	1 ☐ Yes 2 No  27. Manner of Death		npatient 2 ER/Outpatien	t 3 DOA Other: 4	Nursing Home 5 Re		pecify)
9	ding it.	tlon	1 Natural 5 Pending 2 Accident investiga		of Injury th, Day Year) 28b. Time of Injury	28c. Injury at Work? M 1 ☐ Yes		e how injury occurred	
Visi	Attendi	Ifica	3 Suicide 6 Could no	t be	of Injury - At home, farm, strong, etc. (Specify)			(Street and Number or	Rural Route Number
ä	Hospital or 24 hours ette Funeral Dir tely tilled in I	Certification:	4   Homicide	buildir	ng, etc. (Specify)		City or T	own, State)	The state of the s
	hour mer y till		29a. Certifier 1 Certifying (Check only 2 Medical E	Physicien: To the	best of my knowledge, death	occurred at the time, da	te and place, and due to th	e cause(s) and manner	as stated.
	5 4 13 19	_	one)	and mann	ner stated.				ue to the cause(s)
	the Ho thin 24 the Fu	Medic	20h Signaluse and title of and ities			29c. License num	ber		
	To the Hospital or Attendi within 24 hours eiter death. To the Funeral Director: A completely tilled in by the fu	Medical	29b. Signalure and title of certifier	1			06		nth, Day, Year)
• 2	A17.	Medic	1	no completed course	e of death /Hom 23a) (Time	D449	96	OCTOSE!	
• ;	To the Ho Within 24 To the Fu completel		30. Name and address of person w			D 449		October	18,2006
• ;	A17.		1	.20311 LA	e of death (Item 23a) (Type, I PPANS ROAD, B gistrar's Signature	D 449 000NSBORO, M		October	18,2006

			1 - For State Registrar	State of Ma		artment of		Mental Hyg	iene 006	3462
			Decedent's Name (First, Middle, I	ast)				2. Date of Deat		3. Time of Death
	Physic		ANGELENA POSPE	SHILL THOMA	S			OCTOBER	8, 2006	9:35 A
,	/Medi Exami		4a. Facility Name (If not institution, g			4b. City, Town	, or Location of Dea	ath	4c. County of Deat	
	EXGIIII		MALLARD BAY CARE	CENTER		CAMBRI	DGE		DORCHEST	ER
	Funeral				(In yrs. last birthda)	) If Under 1 Yea Months Day		(Month Day	Year) Co	hplace (State or Fore
ĸ.	Director		220-09-8342	1□M 2\\\ F	92 Yrs.			JAN. 26	, 1914 MAR	'LÂND
	and w		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or I	ocation				10d. Inside City Lim
C	Manyl 1 eho	ō	MARYLAND DORCHES	STER	CAMBRII	GE.				1 X Yes 2 □
)	158 108 108 108 108 108 108 108 108 108 10	Director	10e. Street and Number	7221	011111111	10f. Zip Code	9	10	0g. Citizen of What Co	untry?
3	filed within 72 hours after deeth with the Maryland Hygiene ther then "natural", or Items 23a or 28a-f show ont, the Medical Examinar must be notified at	0	520 GLENBURN AVI	ENUE		2161	13		USA	
7	deet	Funeral	11. Marital Status	12. Was Decedent E Armed Forces?	ver in U.S. 13	. Was Decedent o	of Hispanic Origin? (	Specify Yes or No- into Rican, etc.)	14. Race - Ame Black, White	
စ္က	or Ite	正	1 Never Married 2 Married	1 ∐Yes 2 ZŽN If Yes, Give	0	1 ☐ Yes 2 🛣 N		, , ,	Specify:	WHITE
ğ	ural',	d by	3 XWidowed 4 □ Divorced	Year or Dates:	100 Day	adamia Harat O-				
ç	n 72	lete	15. Decedent's (Specify only highest of	rade completed)	(Giv	edent's Usual Occ e kind of work dor DO NOT use reti	ne durina most of w	orking	16b. Kind of Business/	naustry
7	withi iene. then	Completed	Elementary/Secondary (0-12)	College (1-4or 5-	F)	IEMAKER			OWN HOM	Ξ
ğ	Hyg other	Be C	17. Father's Name (First, Middle, La	st)	1		18. Mother's Na	ame (First, Middle, M	Maiden Sumame)	
Maryland 21215-0036	s 1 end 2 should be filed within 72 hours after deeth with the Marylan f Health and Mental Hygiene. Item 27 is marked other then "natural", or Items 23s or 28s-f show other traumatic event, the Medical Examinat must be notified at	To B	CHARLES LOUIS PO	SPESHILL			MARY	HOLECHECK		
a	2 should and Men le marke sumatic		19a. Informant's Name/Relationship		19b. Mai	ling Address (Stre	et and Number or F	Rural Route Number,	City or Town, State, 2	lip Code)
	end 2 fealth m 27 her tra	'	BETTY T. PLUMMER	/DAUGHTER			E BRIDGE		LOCK, MD 2	
altimore,	Peges 1 nent of Ho int: If Iter iry or oth		20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3	☐Removal from State		ematory or other p			20c. Location - City or	Town, State
Ξ	Per tant:		4 □Donation 5 □Other (Spec				UNSEL 10/1		SECRETARY,	MARYLAND
Bai	permit. Peges Department of Important: If It any Injury or o		21. Signature of Funeral Service Lic	ensée )	Man Z	ELLER FU	NERAL HON	ME. P. O.	BOX 207 IARKET MD 2	1631
		1	25a. Party. Enter the disease, or of	molications that caused						Approximate
			shock, or heart failure. List on Immediate Cause (Final	y one cause of each lin	ө.		,, 9,	,		Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)		consequence of):					10 year
	Examiner				econsequence or).					
		Je.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	0	consequence of):					
	cuted	Examiner	that initiated events	c						
o,	e exe en ar urial-t	EX	resulting in death) Last	Due to (or as a	consequence of);					
8760	The law requires that the death certificate be executed the has been signed by the ettending physicien and page 2 should be deteched for use as the burial-transit	dlcal		d						
Q X	entific ding p	/Mec	IF FEMALE:	23c. If yes, outcome of	of programm					
X R R	ettend for us	lan	23b. Was decedent pregnant in the past 12 months?	1□Live birth 2 4□Pregnant at t	2 ☐ Fetal death 3	☐Ectopic pregnar☐Other (specify)			23d. Date of deli Month	very Day Year
o.	that the death certific ed by the ettending p deteched for use as	yslc	1 □Yes 2 Mo 9 □Unknown	9□ Unknown	ane or dealing	Li Ottier (specify)				
2	res that (igned b)	by Physician/Me	Part II. Other significant conditions	contributing to death bu	t not resulting in the	underlying cause	given in Part I.	23e. Did tob	acco use contribute to	the cause of death?
g	pures n sign	d b						1 □ Ye	s 250No 3□Pro	obably 4 Unknow
Vital Records,	w requir s been si should	Completed						24a. Was ar	24b. Were au	topsy findings availal
Ÿ	The la	E						autopsy perform	ned? death?	completion of cause of
īa		BeC	25. Was case referred to medical				26. Place of De	eath (Check only one	~	
	nysic nis ce direc	To	examiner? 1 □ Yes 2 💢 No	Hospital: 1 Inpatier	nt 2 ER/Outpatie	ent 3 DOA	Other: 4 Nursing	Home 5 Reside	nce 6 Other (Spec	:i <b>fy</b> )
0	Attending Physician: The lavar death.  • ctor: After this certificate has by the funeral director, page 2		27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date of Injury (Month, Day	Year) 28b. Time Injury	W		28d. Describe ho	w injury occurred	
<u> </u>	leath. leath. for: A	catl	2 Accident investigat 3 Suicide 6 Could not	he			☐ Yes 2 ☐ No	100		
Division of	or At ifter d Direct in by	Certification:	4 Homicide determine		ry - At home, farm, s . (Specify)	treet, factory, offic	æ	City or Town	eet and Number or Ru , State)	ral Route Number,
_	To the Hospitel or Attanding Physician: within 24 hours after death To the Funeral Director: After this certifica completely filled in by the funeral director,		29a. Certifier Certifying	Physician: To the best o	f my knowledge des	th occurred at the	time date and place	e and due to the co	usa(s) and manner an	stated
	24 h Fun etely	Medical	(Check only 2 Medical Exone)	aminer: On the basis of and manner stat	examination and/or i	nvestigation, in my	y opinion, death occ	curred at the time, da	ite and place, and due	to the cause(s)
	Fo the vithin Fo the	Me	29b. Signature and title of certifier			29c. Lice	nse number	29	d. Date signed (Monti	i. Day, Year)
	C > E 0		Bahnes	n 000		1405	9973		10/11/0	6
			30. Name and address of person wh	completed cause of de	ath (Item 23a) (Type	, Print)	0 /		10/11/0. 10 2/0	
			PJohnson	100 B	ramble	5+	Cambr	idge h	10 210	013

DHMH 17 Rev 1/2001

State Registrar

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day,

32. Registrar's Signature

1 6 2006

		•	For State Registrar	State of N	Marylan			nt of H		nd Me	ental Hy	/gien	000	6	31,6	23
	Diam'r.		1. Decedent's Name (First, Middle,	•						1	2. Date of D Month			'ear	3. Time of [	_
	Physici /Medic		Marie Press								oct	11	2	006	1:35	2 PM
	Examin	er	4a. Facility Name (If not institution, University of I			1 Center			Location of I			40	c. County of	) Death		
	Funeral			S. Sex 7.		last birthday)	If Und	er 1 Year s Days	If Under 24	Hrs.	8. Date of 8 (Month, D	irth av, Year	.) 5	Birthpl Coun	lace (State or	r Foreign
	Director		215-44-4821 Usual Residence of Decedent	1 □ M 2 🛱 F	85	Yrs.					June 2	<b>0,19</b>	21		nnessee	3
	yland now		10a. State 10b. County		10c. Cit	ty, Town or Lo	cation							10	0d. Inside City	y Limits
	Sa-1 of	Director	MD Calve	rt		Owing	js								1 🗆 Yes	2 No
	with th		10e. Street and Number				10f. 2	ip Code				10g. C	itizen of Wh	at Coun	try?	
	ns 234	Funeral	6540 Academy Dr	IVE	nt Ever in U	J.S. 13. V	Was Dec		736 spanic Origir	n? (Spec	ofv Yes or N	0-	14. Race -		an Indian,	
936	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 Is marked other then "naturel", or items 23s or 28s-1 show other traumatic event, the Madical Examinal must be notified at	5	1 ☐ Never Married 2 ☐ Marrie 3 🖁 Widowed 4 ☐ Divorced	Armed Force  d 1  Yes 2  If Yes, Give  Year or Date	₩No				spanic Origir n, Mexican, I Specify:	Puerto R	lican, etc.)		Black, Specify:	white, o		
21215-0036	72 ho	Completed	15. Decedent's (Specify only highest			16a. Dece	kind of v	vork done d	luring most o	of working	q	16b. l	Kind of Busi	ness/Ind	lustry	
121	within ne. ihen "	npl	Elementary/Secondary (0-12)	College (1-4d	or 5+)	life.	DO NOT	use retired	)				la .			
д 7	e filed within al Hygiene. I other then " vent, the Mei		12 17. Father's Name (First, Middle, L	ast)		110	omem	aker	18. Mother's	s Name (	(First, Middle		own ho n Sumame)			
<u>ıla</u> n	uld be Mental rked rtic ev	To Be	Daniel	Presson					Lula	L			Ball	ard		
Maryland	2 should be to and Mental be nearked or raumatic eve	7	19a. Informant's Name/Relationshi	p (Type, Print)		19b. Mailir	ng Addre	ss (Street a	and Number	or Rural	Route Numi	ber, City	or Town, St	ate, Zip	Code)	
	s 1 and 2 of Health Item 27		R. Brooke Kaine 20a. Method of Disposition	, son-in-l		9540 Place of Dispo			Court	, Ow			20736 ocation - C	by or To	wn State	
nor	Pages nert of int: If It		1 X Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Sp.		te C	cemetery, crer Veter	natory o	r other plac					eltenh	•		
Baltimore,	보투를 걸		21. Signature of Funeral Service Li		1.2				s of Facility	0 10	2000	Care	210014	,		
ä	Depa Impo eny le		William	R.Gu	~	R	ausc	h Fun	eral H	Iome	, P.A.	, ov	wings,	MD	20736	
*	Physician /Medical Examiner	ner	23a. Part1. Enter the disease, or o shock, or heart failure. List o Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury)	a. Panci Due to (or	as a consec	Squence of):		Sub Graying	g, 3001 23 Co	ardiac or	respiratory			C	Approximate Interval Betwood Onset and D	veen Death
68760,	ificate be executed g physiclen and as the burial-transit	edical Examiner	that initiated events resulting in death) Last	c. Due to (or	as a conseq	quence of):										
P.O. Box	that the death certific ed by the ettending f detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcor 1□Live birth 4□Pregnan 9□ Unknowr	2 ☐ Feta t at time of c	al death 3	Ectopic Other (	pregnancy specify)			····		23d. Date (			'ear
rds, P	sign d be	5	Part II. Other significant condition	s contributing to deat	h but not res	sulting in the u	nderlying	cause give	en in Part I.						e cause of de ably 4 ∐Ui	
Vital Records,	The law ete hes b pege 2 s	Completed								_	24a. Wa auto per 1 Yes	s an opsy omed? 2 X N	dea	ore autopor to con ath? Yes	osy findings a npletion of ca	ivariable ruse of
/ita	Physician: Th this certificate ral director, peg	Be	25. Was case referred to medical examiner?	Hospital:	,			0#		of Death	(Check only	one)				
Division of	Phys this aldii	tlon: To	1 Yes 2 1 No  27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of I (Month,		ER/Outpatier 28b. Time o Injury		28c. Injury Work	4 🗀 (14013	28	e 5 Res				)	
Divisi	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the funer	Certification:	3 Suicide 6 Could no 4 Homicide determin	ot be 28e. Place of	Injury - At h etc. (Special	ome, farm, str fy)					8f. Location City or To			or Rura	i Route Numb	ber,
	he Hospital n 24 hours a he Funeral ( pletely filled	edical	29a. Certifier 1 Certifying (Check only one)	Physician: To the be xeminer: On the basis and manner	s of examina	owledge, death ation and/or in	h occurre vestigation	d at the tim	e, date and pinion, death	place, ar	nd due to the d at the time	e cause(:	s) and manr nd place, an	ner as st d due to	ated. the cause(s)	
	To the within 2. To the I complet	ž	29b. Signature and title of certifier	Process A	1 /			9c. License					ate signed (			
				Kancak M				740	14			UC	TOYOR	- 11	, 2006	0
	ID		30. Name and address of person w Seema Nayak A	no completed cause of $1.D. 22S$	death (Iter	m 23a) (Type, - Strect	Print)	(Him	ore M	02	1201					
7	Sta Registi		Seema Nayak A 31. Date filed (Month, Day, Year) OCT	1 7 2006	istraly's Signa	ature J.	10	entis								

State of Maryland / Department of Health and Mental Hygiene 006 34624 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Year Month Physician MARY JANE WILLIAMS 0246 18 06 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner ENINGUA SALISBURG Wiennics Kegional If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex Age (In yrs. last birthday 8. Date of Birth (Month, Day, Jan. 25, Birthplace (State or Foreign Country) **Funeral** Days 1 ☐ M 2 🔀 F Hours 513-14-7878 83 Director Kansas Usual Residence of Decedent 10a State 10h. County 10c. City, Town or Location 10d. Inside City Limits in then "natural", or frems 23s or 28s-f show the Medical Expoliner must be notified at ty⊡Yes 2 No Maryland Somerset Crisfield Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21817 U.S.A. 401 Dock Street Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☑Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White 1 ☐ Yes 2X No ð 3 ☐Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72 Depertment of Health and Mental Hygiene. Important: if item 27 is marked other than "na any injury or other traumatic avent, the Medic once. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker At Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Louis E. Lair Inez B. Mudd 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 401 Dock St. - P. O. Box 6 - Crisfield, MD Harold A. Williams (Husband) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 € Cremation 3 ☐ Removal from State Salisbury Crematory 10/20/06 Salisbury, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fine at Scor certicing ee 22. Name and Address of Facility Bradshaw & Sons Funeral Home Robert H. Bradshaw 306 W. Main St. - Crisfield, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** word 21 mo /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine attending physicien and for use as the burial-transit certificate be executed Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death signed by the aid be detached for 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown been sl Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 2 No 1 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Diractor: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2 🗙 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) မှ 1 Inpatient 2 ☐ ER/Outpatient 3□ DOA 27. Manner of Death tX Natural 2 ☐ Accident 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Yes 2 No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29b. Signature and title of sertifier 29c. License number 29d. Date signed (Month, Day, Year) 20507 10/18/06 amo 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CARRILL St SALISBURY MO 31. Date filed (Month, Day, Year) JRNS50 32. Registrar's Signature State Registrar OCT 2 0 2006

51314

21215-0036

Maryland

Baltimore,

Box 68760

P.O.

Records.

of Vital

Division

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Month Year **Physician** 18, 2006 3:45 FRANCES B. WINTERLING October /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 108 Hall Drive Salisbury Wicomico If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year May 3, 19 Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🂢 F Director Yrs 88 Maryland 218-07-0987 Usual Residence of Decedent with the Maryland 10a, State 10b. County 10c. City, Town or Location in then "natural", or items 23a or 28e-f show the Medical Examinar must be notified at 10d. Inside City Limits 1XXYes 2 □ No Maryland Wicomico Salisbury Direct 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours atlar death a Department of Health and Mentat Hygiene. Importent: If item 27 is marked other then "natural", or items 23a any injury or other treumatic event, the Widdel Examiner rust ange. Funeral 108 Hall Drive 21801 TISA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puento Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: White þ Specify: 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Licensed Practical Nurse Nursing Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Freeman McNamara Hazel Tull 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) J. Wayne Price (Personal Representative) 413 Washington Street - Salisbury, MD 21804 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State XBurial 2 Cremation 3 Removal from State \* 4 □ Donation 5 □ Other (Specify) Sunnyridge Memorial Park | Oct. 21, 2006 Crisfield, Maryland 21. Signature of Funeral Service Licensee

Mary Beth Bradshaw—Pruitt

22. Name and Address of Facility
Bradshaw & Sons Funeral Hor

306 W. Main Street - Crist

23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 22 Name and Address of Facility
Bradshaw & Sons Funeral Home 306 W. Main Street - Crisfield, MD 21817 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** rel wascular day /Medical Due to (or as a consequence of): Examiner Mension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a co sequence of) signed by the attending physician and d be detached for use as the burial-transit certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 2 1 NO 9 Unknown 9 Ulnknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? this certificate 1 ☐ Yes 2140 2 No 1 Tyes of or Attending Physician: after death, Director: After this certification 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Nesidence 6 Other (Specify, Hospital: 1 ☐ Yes 2 ☑ №6 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27 Manner of Death 28b. Time of Certification: 28d. Describe how injury occurred 1 Natural 5 Pending investigation To the Hospitel or Attendir within 24 hours after death.
To the Funerel Director: At completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Portifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 18,2006 Wenned ho 1) 15384 odney 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) mb RODNEY A. 1346 S. DIVISION ST. SALISBURY WENRICH 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Eleve & Sports Registrar

State of Maryland / Department of Health and Mental Hygien 006 34626 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year Catherine Creighton Willey October 12, 2006 12:15 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Dorchester Chesapeake Woods Center Cambridge 5. Social Security Number If Under 1 Year 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1 ☐ M 2 🖫 F Days Hours Yrs. Director 216-14-9517 83 Sept 10,1923 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Item 27 is marked other then "natural", or Items 23a or 28a-1 show other traumatic event, the Mactical Examinar must be notilitied at Maryland Dorchester Vienna 1 ☐ Yes 2XXNo Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3865 DeCoursey Bridge Road 21869 US 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. hours after ☐Yes 2 No Yes. Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2☐No Specify: à X Widowed 4 □ Divorced Specify: Yes, Give Year or Dates: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 12 should be filed within 7. h and Mental Hygiene. 7 ie marked other then "n. Elementary/Secondary (0-12) College (1-4or 5+) 11 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Everett P. Creighton Mary Mildred Kirby ٥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 ie m eny injury or other traum once. Ann W. Cook Daughter 4336 Fork Neck Road Vienna, Maryland 21869 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Ty Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10/14/2006 | Cambridge, Maryland Dor. Memorial Park 21. Signalure Funeral Service Licensee Thomas Funeral Home, P.A. 700 Locust Street Cambridge, Maryland 21613 23a. Part | Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shoot, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final End **Physician** Sta Ce Domen hà disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner signed by the attending physicien and I be detached for use as the burial-transit the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4□Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 🗆 Yes 2 No 3 Probably 4 Unknown certificate has been s irector, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 1 Yes 2010 2 2000 Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3□ DOA this : After thi 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural Injury 5 Pending death. 1 ☐ Yes 2 ☐ No after death Director: / 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, elc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital o within 24 hours aft To the Funeral Di completely filled in Medical 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certified 29d. Date signed (Month, Day, Year) lau 47924 10:12-06. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NOMAN 300 AURORA MD 216/3 THANK CAPTERIDEE 2006 Registar's Signature 31. Date filed (Month, Day Registrar

1 - For State Registrar

Certificate of Death

34627

2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Frederic Wayne Willett Month Year **Physician** RIPORKICK 6.49 OCTOBER 14 2006 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner CENTER BALTIMURE RALTIMORE CITY MERCY MEDICAL If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1**⊠**M 2□F Yrs. Director FEB.7,1942 MARYLAND 64 215-42-2455 Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r then "natural", or items 23s or 28s-f show the Medical Examirar roust be notified at 1 ☐ Yes XXNo Directo LA PLATA MARYLAND CHARLES 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. 11375 FAIR FOUNTAIN FARM ROAD 20646 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes \$170No If Yes, Give X Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No WHITE Specify þ 3 ☐ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) GSA U.S. GOVERNMENT COMPUTER ANALYST 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 0 JAMES HARRISON LEE WILLETT NELLIE LORETTA COOMBS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Depertment of Heelth and Important: if item 27 is m any injury or other traum 2005. ANITA HAYNES-DAUGHTER 11375 FAIR FOUNTAIN FARM RD., LA PLATA, MD20646 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition t. Pages 1 1 ▼Bunal 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) ST.JOSEPH'S CH.CEM. 10-19-06 POMFRET, MARYLAND 21. Signature of Funeral Service Licensee MOO479 22. Name and Address of Facility RAYMOND FUNERAL SERVICE, P.A. uhr LA PLATA, MARYLAND 20646

Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) YPOXIA **Physician** /Medical Due to (or as a consequence of) Examiner failure Vatory Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine physicien and the burial-transit Hospital or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ 3 Probably 4 ⊕Unknown 1 ☐ Yes 2 ☐ No GESTIVE HEART FAILURE Be Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No OYIOLISM autopsy performed? ARTER-URUNARY 2 100 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Impatient 9 1 Yes 2 No 2 ER/Outpatient 3 DOA his 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? After t 28d. Describe how injury occurred Certification: 5 Pending 1 -Natural Injury 1 ☐ Yes 2 ☐ No investigation 2 Accident the Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - Al home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral C 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and little of certifier MO AU4176435 L1587 tober 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M. D. 30. Segistrar's Signature 30 ST. PAUL PLACE JEFFERSON MARYLAND 31. Date filed (Month, Day, Year) 0CT 3 1 State

Registrar

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

rry Evan Wrig	1	State of Maryland / Departr - For State Certific	ment of icate of		Mental Hy		Reg No. 200	6 34628
Physicia	ın/	Decedent's Name (First, Middle,Last)				<ol><li>Date of De Month</li></ol>	Day Year	3. Time of Death
edical Examii		Kerry Wright		b. City, Town, or Lo	eastion of Dooth	October	14, 2006 4c. County of Dea	0945 hrs
		4a. Facility Name (if not institution, give street and number) 2408 Bright Seat Road Apt 5	41	Landover	ocation of Death		Prince Georg	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last I	oirthday)	If Under 1 Year	If Under 24Hrs.	8. Date of B		irthplace (State or Foreign
Director		127.72.5357   1×1 × 2 F   43	Yrs.	Months Days	Hours Min.	08/19	0/1963 °	ountry) NY
	+	Usual Residence of Decedent		<u> </u>	<u> </u>	100715	7.550	
v any	Γ	10a. State 10b. County 10c. City, To	wn or Location	on				10d. Inside City Limits
Maryland 28a-f show any d at once.	ō L	MD Prince George Lando	ver					1 Yes 2 No
Many r 28a- ed at	Director	10e Street and Number		10f. Zip Code		Ì	10g. Citizen of What Co	untry?
15-0036 filed within 72 hours after death with the Maryland I Hygiene do other than "natural", or items 23a or 28a-f sho i, the Medical Examiner must be notified at once.		2408 Bright Seat Road #5	12 1//05	20785	anla Osigina / Ca	2061 Van 25 h	USA	ricen Indian Plank
death wi	Funeral	11. Marital Status  1 X Never Married 2 Married Armed Forces?  Armed Forces?		Decedent of Hisp es, specify Cuban,			White, etc.	erican Indian, Black,
ter de	- 1	1 Yes 2 No 3 Widowed 4 Divorced If Yes, Give Year	1	Yes 2 X No	specify:		Specify: B]	ack
urs af	d b	15. Decedent's Education (Specify only highest grade completed) 16	a. Decedent	's Usual Occupation	on (Give kind of w		16b. Kind of Business	
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vithin ene er tha	Comple	12	Secur	ity Offi				nstruction
filed oth		17. Father's Name (First, Middle, Last)					, Maiden Surname)	
21215-0036 uld be filed within 7 Mental Hygiene marked other than	o Be	Jessie L. Wright  19a. Informant's Name/Relationship (Type, Print)	19b. Mailing	Address (Street	Mildred and Number or F	SKinne Rural Route N	E <u>r</u> umber, City or Town, Sta	te, Zip Code)
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after ment of Health and Mondal Hygieweith and I strength and I strength and I strength of the ment of the marked other than "natural", or other traumatic event, the Medical Examiner.	-	Mildred Wright, mother	30 Ave	nue D#	12F. Nev	v York.	NY 10009 20c. Location - City	
e, le land land Healt litem			ce of Disposi	tion (Name of cem	netery,	Date	20c. Location - City	or Town, State
TOT Pages ent of nt: 11		T Obullar 2   Clettlation 3   Iteliovalitoni State	-	Memorial	Pk. 10.	21.06	Chesapeak	ke, VA
Baltimore, permit Pages I and Department of Heal Important: If iten		2 Sig ature of Funeral Se (c)	22. N	ame and Address	of Facility		122 F Bor	klev Avenue
1:1 5 6 M		Kom VIIII ON	Me	tropolit	an Funer	al Svo	·Norfolk. V	A 23523
Physician /Medical		23a. P. t I. Iter the earl, or complications that caused the death. Defailur List only ne cause on each line.				r respiratory a	rrest, shock, or heart	Approximate Interval Between Onset and
Examiner		Immediate Cause Final disease or condition resulting in death)  a. Complications of  Due to (or as a consequence of):	chronic	alcohol a	buse			Death
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	ner	Sequentially list conditions, if any, leading to immediate  Due to (or as a consequence of):						
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760, cate be physic the bur	/Me	IF FEMALE: 23c. If yes, outcome of pregnal	ncy				23d. Date of delive	,
Sox 6876 death certificate e attending phy	sician/	23b. Was decedent pregnant in the past 12 months?	, - =	tal death 3	Ectopic pregna	ancy	Month	Day Year
Box death c the atten	ysic	1 Yes 2 No 9 Unknown 9 Unknown	5 ∐ Ot	her (Specify)				1
O. E at the d by th	y Phy	Part II. Other significant conditions contributing to death but not resu	ulting in the u	ınderlying cause g	iven in Part I		tobacco use contribute	
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of Vital Records, ng Physician: The law requir ther this certificate has been s meral director, page 2 should I	To B	1 ✓ Yes 2 No lospital 1 Inpatient 2 E	R/Outpatient	J DOA		ng Home 5	Residence 6 🗸 Ott	ner Scene
n of ling Ph After I		1 V Notural (Month, Day, Year)	8b Time of I		ry at Work? /es 2 No	28d. Describ	e how injury occurred	
Sior Attenc r death ector: by the	catic	2 Accident Investigation	- 6			204 Leaster	/Chrost and Number or	Dural Bauta Number City
Division tal or Attendit safter death al Director: △	ertification	3 Suicide 6 Could not be determined (Specify)	ie, rarm, stre	et, ractory, office b	unaing, etc.	or Towr		Rural Route Number, City
Ospit:	ပ	29a. Certifier 1 Certificing Physicians. To the best of my knowledge	death occu	rred at the time, da	ate and place, and	due to the c	ause(s) and manner as s	tarted
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Medical	one) 2 Medical Examiner: On the basis of examination and	l/or investiga	tion, in my opinion	, death occurred	at the time, da	ate and place, and due to	the cause(s)
To To	Mec	29b. Signature and title of certifier		29c. Licens	e number		29d. Date signed (/	Month, Day, Year)
		Man IV		O.C.1	M.E.		October 15, 20	006
		30. Name and address of person who impleted cause of death (Item 2	3a)					
		Susan Hogan MD. Assistant Medical Examiner		nn Street, Balt	imore, MD 2	1201		
	state	7 7 1 1 1 1 7 1 7 1 1 1 2 1 1 2 2 1 2 2 2 2	N A	marke)				
Regi	strai	UC 1 3 1 2000 Julies 3	D Par	Detr. Age				

			For State State Registrer		partment of Health ertificate of Death		rgiene 006	34629
			Decedent's Name (First, Middle, Last)			2. Date of Do	eath	3. Time of Death
	Physici /Medic		Julia Olive Zel	enski		Month Oct	Day Year 17 2006	6:22 AM
	Examin	A	4a. Facility Name (If not institution, give street and		4b. City, Town, or Location	of Death	4c. County of Dea	
			Genesis HealthCare		Eastor		Talb	
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birthda	y) If Under 1 Year If Under Months Days Hours	Min. 8. Date of Bi	rth ay, Year) 9. Bi	rthplace (State or Foreign country)
	Director		579-28-1582 Usual Residence of Decedent	80 Yrs.		July 18	3, 1926 Wash	nington,DC
	land ow		10a. State 10b. County	10c. City, Town or	Location			10d. Inside City Limits
	Mar.	tor	MD Caroline	Feder	alsburg			1 ☑ Yes 2 ☐ No
	th the	Director	10e. Street and Number		10f. Zip Code		10g. Citizen of What C	ountry?
	23a		404 Old Denton Road		216		United St	ates
	ar de tams	Funerai	Armed	ecedent Ever in U.S. 1: Forces?	<ol> <li>Was Decedent of Hispanic Of If Yes, specify Cuban, Mexica</li> </ol>	rigin? (Specify Yes or Nan, Puerto Rican, etc.)	o- 14. Race - Am Black, Wh	
36	hours after death with the Maryland turel', or tlams 23e or 28e-f show at Examiner must be notified at	by F	If Yes,	s X□No Give r Dates:	1 ☐ Yes 21 No Specify	y:	Specify:	White
8	n 72 hours after death with the Marylan "natural", or Itams 23a or 28e-f show clical Examiner may be notified at		15. Decedent's Education	16a. De	cedent's Usual Occupation		16b. Kind of Busines	s/Industry
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21	illed withir Hygiene. other than	Completed	12	Ow	ner		kestaurai	it Business
Maryland 21215-0036	be filed ntal Hygi ed other event, I	Be	17. Father's Name (First, Middle, Last)	÷		her's Name (First, Middle		
<del>y</del> a	ould be I Mental parked o	<sup>c</sup>	James Edward Curt			na May Dar		
Mai	12 st h and 7 is n traun		19a. Informant's Name/Relationship (Type, Print) Stanley Zelenski/Sp		iling Address (Street and Numi Old Denton		•	
e)	1 an Heall tam 2		20a. Method of Disposition	20b. Place of Dis	position (Name of	Date	20c. Location - City o	
no	ages ant of it: If it		Burial 2 □ Cremation 3 □ Removal from 4 □ Donation 5 □ Other (Specify)	om State Eastern	Sh. Veterans	10/20/06		Maryland
Baltimore,	artme ortan injur		21. Signature of Funeral Service Licensee	Jan John	22. Name and Address of Faci			
m	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic e one.		Muhael 7. Est	w	216 N. Main	St., Fede	eralsburg,	MD 21632
			23a. Part1. Enter the disease, or complications the shock, or heart failure. List only one cause of	at pused the death. Do not e	enter the mode of dying, such a	s cardiac or respiratory	arrest,	Approximate Interval Between
	Pnysician	1	Immediate Cause (Final disease or condition	Aspiration 10	neumanna			Onset and Death
1	/Medical Examiner		resulting in death)	to (or as a consequence of):	1 4			
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JS,	ires tha signed l	l by	Dehelican allen	o death but not resulting in the	underlying cause given in Pan		tobacco use contribute  Yes 2 □ No 3 □ F	Probably 4 Unknown
Ö	w require been si should b	etec	Come I de la la la la la la la la la la la la la					
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Vital		e Co	25. Was cas rred to medical		00 81-	1 ☐ Yes	2 No 1 ☐ Ye	s 2 No
5	Physician: this certific ral director,	0 8	examiner: Hospital:	☐ Inpatient 2 ☐ ER/Outpat	Other	ce of Death (Check only ursing Home 5 Res		eciti)
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Division	or Attanuater death Diractor:	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Pl	ace of Injury - At home, farm, illding, etc. (Specify)	street, factory, office		(Street and Number or F own, State)	Rural Route Number,
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	To tha Hospital or Att within 24 hours after d To tha Funaral Diract completely filled in by	Medical	(Check only 2 Medical Examiner: On the	the best of my knowledge, de e basis of examination and/or nanner stated.	ath occurred at the time, date a investigation, in my opinion, de	and place, and due to the eath occurred at the time	e cause(s) and manner a , date and place, and du	is stated. le to the cause(s)
	o tha	Me	29b. Signature and title of certifier	7	29c. License number	r	29d. Date signed (Mor	nth, Day, Year)
	- > - 0		> 1MM	no not	772	5933	10.17	2-06
			30. Name and address of person who completed	ause of death (Item 23a) (Tyr		, ,	, MA	0.00
			MICHAEL ROWLEY	ND 610 7	Dutchmans 1	WANE K	ASTON, 1111	21601
	Sta		31. Date filed (Month, Day, Year) 33. OCT 1 3 2006	2. Registrar's Signature	March 1		,	
	Regist	di	001 1 0 2000	TOURDAY JO.	1			

# IIRGINIA AXIE'

2	Baltimor	permit Pages
		PI E
	cords, P.O. Box 68760, 🌋	aw requires that the death certificate be executed

Division or Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) October 27, 2006 **Physician** 4:04 MARY VIRGINIA NAYLOR AXLEY рм /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel Baltimore-Washington Medical Center Glen Burnie 8. Date of Birth (Month, Day, Year March 11, If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign **Funeral** Days Hours Min. 1912 Wash., DC 1 □ M 2 🖳 F 577-18-7343 Director Usual Residence of Decedent 10a State 10b County 10c. City, Town or Location 10d. inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Funeral Director Anne Arundel Laurel Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20724 U.S.A. 325 Brock Bridge Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14 Bace - American Indian. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. es 1 and 2 should be filed within 72 hours after of Health and Mental Hygiene. of Health and Mental Hygiene. f item 27 Is marked other than "natural", or ite 1 Never Married 2 Married 1 ☐ Yes 2 📉 🗓 XIo Specify: Specify: Be Completed by White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16h Kind of Business/Industry Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Telephone Company Teller Grade 10 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mary Taylor Henry Naylor ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Mary Maness 821 Creel Drive Hampstead, Maryland Department of Health Important: If item 27 any injury or other tra daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1K Burial 2 ☐ Cremation 3 ☐ Removal from State 11/2/2006 Washington, DC Congressional Cem. 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Donaldson Funeral Home, P.A. GR / M00770 313 Talbott Avenue Laurel, Maryland 20707 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Aorbic immediate Cause (Final disease or condition resulting in death) Due to (or as a conrequence of): nysician bleedin sudden. Medical xaminer Mornic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hyputens and burial-tra Due to (or as a consequence of) physician Physician/Medical the as aftending IF FEMALE for use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Dav in the past 12 months? 1 ☐ Yes 2 🕱 No 4□Pregnant at time of death 5 ☐ Other (specify) the detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ pe 1 Tes 2 No 3 Probably 4 Unknown Be Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No —— 24a. Was an autonsy perform Hospital or Attending Physician: The 2 No 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 🔲 Inpatient 2 ER/Outpatient 3□ DOA Certification: To this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No n 24 hours after death.

The Funeral Director: A pletely filled in by the 2 Accident death 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 retifying Physician: To the best of my knowledge, death occurred at the time, date and piace, and due to the cause(s) and mainter as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) completely To the Vithin 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number n Melita 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) URVIMENTA 31. Date filed (Month, Day, Year) NOV 0 1 2006

DHMH 17 Rev 1/2001

State Registrar strar's Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 10 **Physician** 2006 01:52 a M Louis Raymond Amorose /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Rosedale Manor Care Rossville If Under 1 Year | If Under 24 Hrs. Date of Birth Month, Day, Year) 01/13/1927 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday **Funeral** Days Hours Months Min. 1**X** M 2□F 79 219-22-4908 Director Pennsvlvania Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 1 ☐ Yes 2 X No Director Baltimore MD Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 9225 Harford View Drive 21234 Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes ≥ 2 No
If Yes, Give
Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black White etc. 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No ģ Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Xerox Technician Information Technology 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lillian Rost ပ္ Frederick Amorose 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9225 Harford View Drive, Baltimore, MD 21234 Kathryn Amorose, Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Wm. Watters Memorial 11/03/06 Jarrettsville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Leonard J. Ruck, Inc. Mayondre Baltimore, MD 21214 5305 Harford Road 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on the line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical as a consequence f) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Examine Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1∐ Yes 2 No 25. Was case referred to medical examiner? Be ( 26. Place of Death (Check only one) Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 ☐ No Hospital: Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3□ DOA After this in by the funeral 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident Director 3 ☐ Suicide 6 □ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a To the Funeral C Lecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier (Check only one) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year)

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DHMH 17 Rev 1/2001

32. Redistrar's Signature

1 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 34632 State of Maryland / Department of Health and Mental Hygien 🖓 [] 1 - For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** Josephine Glassman Adams /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Thes! Year If Under 1 Birthplace (State or Foreign Country) Sex last birthday 8. Date of Birth (Month, Day, **Funeral** Days 1□M 21 F 212-22-8054 80 19 Director 1926 Maryland Usual Residence of Decedent with the Marylend 10a. State 10c. City, Town or Location permit. Pages 1 end 2 should be filed within 72 hours after death with the Marylen Depertment of Health and Mental Hygiene important: If item 27 is marked other then "natural", or items 23a or 28a-1 show eny Injury or other treumatic event, the Medical Examiner must be notified at enge. 10b. County 10d. Inside City Limits 1 ☐ Yes 2 X No Directo Maryland Dorchester Church Creek 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 1905 White Haven Rd. 21622 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 No Specify: þ 3 → Widowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Secretary U.S. Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Charles Henry Glassman Josephine (nmn) Burchett 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1905 White Haven Rd., Church Creek, Maryland 21622
se of Disposition (Name of Date 20c. Location - City of Town, State Lois A. Testerman/ Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☑ Bunal 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11-2-06 Bel Air Memorial Bel Air, Maryland 21. Signature of Fundral Service Licensee McComas Funeral Home, P. A. 50 West Broadway, Bel Air, Maryland 21014 23a. Part1. Enter the disease, or complications that aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ONEUMONIA **Physician** 2 dnys /Medical Due to (or as a consequence of) Examiner PSIS > e Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine the death certificate be executed burial-transi physician end Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical use as the ned by the attending detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 4 Pregnant at time of death ☐Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by should be 1 Yes 2 Sto 3 Probably 4 Unknown been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an page 2 autopsy performed 1 ☐ Yes 25 To the Hospital or Attending Physicien: filled in by the funeral director, To Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 2 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 1 Impatient 2 ER/Outpatient 3□ DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification; Natural 5 Pending investigation deeth. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 / Homicide 24 hours a Testifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical within 24 ho

To the Fund

completely f 29b. Signature and title of certifier 29c. License number

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

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2006

address of person who completed cause of death (Item 23a) (Type, Print)

State of Maryland / Department of Health and Mental Hygien ) 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) - PM **Physician** 9:45 AVERY 10 2006 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner UNIVERSITY OF MARY LAND MEDICAL CENTER

5. Social Security Number 6. Sex 7. Age (In yrs. last birthday BAITIMORE If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country)
 Unk 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1 M 2 □ F 1943 63 Mar 8, 219-40-2886 Director Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours efter deeth with the Maryland 10c. City, Town or Location 10a. State 10b. County rthan "naturel", or Items 23s or 28s-f ehow the Mudical Examinar must be notified at 1€ Yes 2 No MD Baltimore Direct 10g. Citizen of What Country? 10f. Zio Code 10e. Street and Number 21201 1027 Cathedral Street USA Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: Specify: black δ 3 ☐ Widowed 4 ☑ Divorced unk | 16b. Kind of Business/Industry Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) unk unk Pages 1 and 2 should be filed vent of Health and Mental Hygient: If Item 27 is marked other try or other treumatic evant. unk unk 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 22 S. Greene Street Baltimore, MD University of MD Med Ctr Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages 1
Department of H
Important: If Itel
eny injury or oth 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □Donation 5 ☑Other (Specify) in state 21. Signature of Funeral Service Licensee Ronald S. Wade 22 Name and Address of Facility Board 655 W. Baltimore Street 23a. Part. Enter the disease, o. m. cations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final INTRACEREBRAL HUMORRHAGE **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). Examine The law requires that the death certificate be executed nding physicien and use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical signed by the attending d be detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year in the past 12 months? 5 Other (specify) 4□Pregnant at time of death 1 Yes 2 No o 9 Unknown م 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by Records. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown should 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performe 2 No 1 ☐ Yes certificate of Vital 26. Place of Death Check only one director 25. Was case referred to medical Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Medical Certification: To this After this 28b. Time of fnjury 28d. Describe how injury occurred 28a. Date of fnjury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 1 Natural 2 Accident Division 5 Pending 1 ☐ Yes 2 ☐ No death. investigation within 24 hours efter death To the Funerel Director: . completely filled in by the f 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide To the Hospital is Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 15817 2006 MI 30. Name and address of person who completed suse of death (Item 23a) (Type, Print) 22 South Greene Street hana 32. Registrar's Signature 31. Date filed (Month, Day, Year) State NOV 0 1 2006 Registrar

			Sta 1 - State Amend item#29d,perMI Registrar	te of Maryland / De 0,G860, 11/1/06 <b>T?</b>	epartment of Health Certificate of Death	and Mental Hy 1	2000	34634
			Decedent's Name (First, Middle, Last)	)		2. Date of De		3. Time of Death
	Physicia /Medic		Leander G	arfield Bro	IUN Sr.	OC +	20 200 (	p 9:30PM
	Examin		4a. Facility Name (If not institution, give street a		4b. City, Town, or Location		4c. County of Dea	
			3119 Bettou Ja 5. Social Security Number 6. Sex	7. Age (In yrs. last birtho	handalls town	r 24 Hrs.   9 Date of Bir	5a1+1m	thplace (State or Foreign
	Funeral Director		213-20-3816 18M 21		Months Days Hours		7, 1925	Md Md
	p ,		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town o	or Location		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	10d. Inside City Limits
	Aaryle r ehov	ŏ	11	0	115to W.N			1 Yes 2 No
	the h	Director	Ma Baltimor  10e. Street and Number	Proposition S	10f. Zip Code		10g. Citizen of What Co	ountry?
	th with		3119 Betlow James	Place	2120	) ¬	USA	
	r dee	Funeral	11. Marital Status 12. Wa	s Decedent Ever in U.S. led Forces?	13. Was Decedent of Hispanic O If Yes, specify Cuban, Mexica		14. Race - Ame Black, Whi	
36	urs after deeth with the Marylen el', or Iteme 23a or 28a-f ehow Examiner must be notified at	by Fi	If Y	Yes 2 □ No es, Give er or Dates:	1 ☐ Yes 2 No Specify	y:	Specify: P	lack
5-0036	n 72 hours after deeth with the Marylend "neturel", or Iteme 23a or 28a-f ehow edical Examinat must be notified at		15. Decedent's Education	16a. D	ecedent's Usual Occupation	ant of working	16b. Kind of Business	
7	within 7 ene. then "r	Completed	(Specify only highest grade comp Elementary/Secondary (0-12)  Col	lege (1-4or 5+)	Give kind of work done during mo ife. DO NOT use retired)	ist of working		
121	D 0 =	Cor	17. Father's Name (First, Middle, Last)	105 10	livistet 18 Mars	her's Name (First, Middle	Baptist Maiden Sumame	Church
Maryland	d 2 should be filed in and Mental Hyg	To Be	Garfield Augustus	Brown		44 James		
ary	shoul and M mari	F	19a. Informant's Name/Relationship (Type, Prin		Mailing Address (Street and Numb			Zip Code)
Σ	2 = 0 -		Phyllis Brown	wife 31	19 Betten Jo	mes Plac	2	
ore	ges 1 ar t of Hea if item or othe		20a. Method of Disposition 1	cometani	disposition (Name of crematory or other place)	Date	20c. Location - City or	Town, State
Baltimor	Pe ant: ury		4 Donation 5 Dother (Specify)		22. Name and Address of Faci	10/30/06	Dw. ngs Mi	115 Md
Ba	permit. Departn Imports eny inju		21. Signature of Funeral Service Licensee		5240 Preisters to	· Onterorne	Baltimore	uneral Home
			23a. Part Enter the disease, or complications spock, or heart failure. List only one caus	that caused the death. Do not				Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	1	MUNONY B	RACIT		Onset and Death
	/Medical Examiner		resulting in death)	ue to (or as a consequence of)	110 met	NS18218		1
		er	Sequentially list conditions, b	ue to (or as a consequence of)	100 14 0001	70100		201000
16	uted d ansit	Examin	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Mitesla	ilappe usily	negura	ication	20 years
0,	e exec ian an urial-tr			ue to (or as a consequence of)	26 dominal	Anewy.	1 21	2.10-1
68760	icate be executed physician and s the burial-transit	edical	d	2,6 CM 1.	12000000000	4	19	14621
_		/Me	IF FEMALE: 23c. If your 23c. If your 23c. If your 23c. If your 23c. If your 23c. If your 23c. If your 23c. If your 23c. If your 23c. If your 23c. If your 23c. If your 23c. If your 23c. If you 23c. If your 23c. If your 23c. If your 23c. If your 23c. If you 23c. If your 23c. If your 23c. If your 23c. If your 23c. If you 23c. If yo	es, outcome of pregnancy			23d. Date of de	livery
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P.O.	ires that the de signed by the a f be detached t	Phys	9 Unknown	Unknown				
	signed bed	ρ	Part II. Other significant conditions contribution  Benfan Ross	g to death but not resulting in the	ne underlying cause given in Part とくくれらりなって	1. 236. Did	obacco use contribute t	robably 4 Unknown
Cor	law requires es been sign 2 should be	ietec		, , , , , , , , , , , , , , , , , , ,		24a. Was		utopsy findings available
Division of Vital Records,	0 5 0	Completed				auto	psy prior to death?	completion of cause of
ital	ysiclen: This certificate	BeC	25. Was case referred to medical examiner?		26. Plac	ce of Death (Check only		20140
₹ 	d is y	ဥ	1 ☐ Yes 2 ☐ No Hospital	1 Inpatient 2 ENOutpa		lursing Home 5 Res		ecify)
U <sub>O</sub>	ding l h. Atter funer	Certification:	1 ☑Natural 5 ☐ Pending	Date of Injury (Month, Day Year) 28b. Tim Inju			how injury occurred	
Visi	Attending or death. ector: Atter by the fune	ifica	3 □ Suicido 6 □ Could not be	Place of Injury - At home, farm		28f. Location (	Street and Number or R	ural Route Number,
ā	rs after or rs after or el Dir	Cert	4   Holliede	building, etc. (Specify)		City or To	wii, State)	
)	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: Atter th completely filled in by the funeral	edicai	(Check only 2 Madical Examinar: Or	To the best of my knowledge, of the basis of examination and/of manner stated.	death occurred at the time, date a or investigation, in my opinion, de	and place, and due to the eath occurred at the time,	cause(s) and manner a date and place, and du	s stated. e to the cause(s)
,	To the within 2 To the complet	Me	29b. Signature and title of certifier		29c. License number		29d. Date signed (Mon	th, Day, Year)
)			1 Tox X/Ser	prog	12203		12-25-0	₹
	\		30. Name and address of person who complete	d cause of death (Item 23a) (Ty	ype, Print) 21/6 Missaeli	2 2 200	Balt.	md 2/2/4
1	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Signature	216 Maryle	1112	- 120 6 60-	-, -, -,
	Registr		NOV 0 1 200	Julien S	12995			

State of Maryland / Department of Health and Mental Hygiene 0 0 6 1 - For State Registra Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 4:00P 1 dMonth 26 2006 ear **Physician** ROBERT JAMES BEHLER /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Fecility Name (If not institution, give street and number) Examiner BALTIMORE MIDDLE RIVER 1211 OREMS ROAD If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7/22/1952 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 54 Months Days Hours Min 1**X**] M 2□ F MARYĽAND Yrs. 213520087 Director Usual Residence of Decedent 10d. Inside City Limits the Maryland 10c. City, Town or Location 10a State 10h County itam 27 is marked other than "natural", or items 23a or 28a-f shov other traumatic evant, the Nedical Examinar must be notified at 1 □ Yes 2 →No MD BALTIMORE MIDDLE RIVER Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 1211 OREMS ROAD 21220 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑No If Yes, Give Year or Dates: 14. Race - American Indian. filed within 72 hours after dee Hygiene. other than "natural", or Items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married WHITE 1 ☐ Yes 2 No Specify: Baltimore, Maryland 21215-0036 þ 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

INS. 16h. Kind of Business/Industry 15 Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 1 2 GOVERNMENT College (1-4or 5+) BALTO. CO. ADMIN.HEALTH 2 should be filed w and Menfal Hygier Is marked other th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) DONALD BEHLER MAE **ISENHOUR** SR. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Importent: If Itam 27 Is m any injury or other traum DENISE A. BEHLER / WIFE 1211 OREMS ROAD BALTIMORE, MD 21220 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 10/28/06 METRÓ CRÉMATÓRÝ BALTIMORE, MD '4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funda Service Licens e 22. Name and Address of Facility CVACH/ROSEDALE FUNERAL HOME 1211 CHESACO AVE BALTO., MD 21237 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician LATERAL SCLEROSIS 19 MONTHS AMYOTROPHIC /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter United lying Cause (Disease or injury Due to (or as a consequence of) Examine ysician and e burial-transif The taw requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Records, P.O. Box 68760 Physician/Medical the attending phy 98 IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Day Month Year 4□Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Tes 2 PNo 3 Probably 4 Unknown Completed been 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? 2 🗆 No 2 🔀 No 1 ☐ Yes 1 Yes Division of Vital To the Hospitel or Attending Physicien: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 🖫 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA 2 this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certification: After 5 Pendina 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident investigation filled in by the Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide efter within 24 hours e To the Funerel I 1 S Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 10,27,2006 D005387 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MARAGAKIS, M.D BALTIMORE, MO 21287 NICHOLAS J. 600 N. WOLFE ST. 32 Registrar's Signature 31. Date filed (Month, Day, Year) State 2006 Registrar

			For State Registrar	State of Mary		artment of h rtificate of			giene 00 (	34636			
ı	Physici		Decedent's Name (First, Middle, Last     ELIDA BLANC	st)				2. Date of De Month October	Day Yea	3. Time of Death 4:44 p M			
2	/Medic Examir		4a. Facility Name (If not institution, give Howard County Gene		1	4b. City, Town, o	or Location of Dea		4c. County of De Howard				
	Funeral Director			OM ADE	yrs. last birthday) 34 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min	8. Date of Bin (Month, Da March	th ly, Year) 15, 1922	irthplace (State or Foreign Country) Haiti			
	fand ow		Usual Residence of Decedent  10a. State 10b. County	10	c. City, Town or Lo	ocation				10d. Inside City Limits			
	Mary a-f eh	tor	Maryland Howard		Elkridg	е				1 □Yes 2□No			
	s with the 3s or 28	i Director	10e. Street and Number 7113 Little Cove	Farm Way		10f. Zip Code 21075	5		10g. Citizen of What (	Country? Haiti			
36	s 1 and 2 should be filed within 72 hours after death with the Maryland I Heelih and Mental Hygiene. Item 27 ie marked other then "naturel", or iteme 23s or 28s-f ehow other traumatic event, its Medical Examiner marke mullind at	by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever Armed Forces? 1 ☐ Yes 22 No If Yes, Give Year or Dates:	r in U.S. 13.	Was Decedent of H If Yes, specify Cub	dispanic Origin? (i an, Mexican, Pue Specify:	Specify Yes or No rto Rican, etc.)	14. Race - An Black, Wh Specify:	nerican Indian, nite, etc. Black			
21215-0036	within 72 hou ene then "nature the Medical E	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12) Grade 6	ducation de completed) College (1-4or 5+)	(Give	dent's Usual Docup kind of work done DO NOT use retire	pation during most of wo d)	orking	16b. Kind of Busines	ss/Industry			
	2 should be filed within and Mental Hygiene. Ie marked other then aumatic event, the Ms	Be Co	17. Father's Name (First, Middle, Last)				18. Mother's Na	ame (First, Middle,	, Maiden Sumame)				
/lan	should be find Mental Homer Mental Homer Mental Homer Mental Ment	To B	Aldolphe Blanc				Charit	e Charlme	е				
Maryland	2 sho		19a. Informant's Name/Relationship (	,, ,					er, City or Town, State lkridge, Ml				
nore, I	permit. Pages 1 and 2 Department of Heelth a Important: If item 27 le eny Injury or other tra <u>9068</u> .		Elifaite Legitime  20a. Method of Disposition  1 Burial 2 Cremation 3	Removal from State	20b. Place of Dispercemetery, cre	Little ( position (Name of matory or other pla Cemeters	ce)	Date 11/2006	20c. Location - City of	or Town, State			
Baltimore,	permit. Pi Departme Important eny Injury		4 □ Donation 5 □ Other (Specification 21. Signature of Funeral Service Licer	y) asee	2	2 Name and Address	an of Engille						
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line.										
5	Physician /Medical		snock, or near failure. List on Immediate Cause (Final disease or condition resulting in death)	a Acute My	ocardial	Infarct				Onset and Death			
	Examiner		1	Due to (or as a co	onsequence of):  / Artery	Disease							
,00	ificate be executed g physicien and as the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a co									
68760,	ficate b	edical	•	d									
P.O. Box (	law requires thet the death certifi es been signed by the attending 2 should be deteched for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of p 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3	□Ectopic pregnanc □ Other (specify) _	у		23d. Date of d Month	delivery Day Year			
	w requires that been signed by should be dete	þ	Part II. Other significant conditions of	ontributing to death but n	ot resulting in the u	inderlying cause gr	ven in Part I.		_	to the cause of death?  Probably 4 □Unknown			
I Records,	The law requiste hes been page 2 should	Completed							an 24b. Were prior to death? 2000 1 1 1 1				
of Vital	iclan: Th certificete rector, pag	Be	25. Was case referred to medical examiner?	Hospital:		0#	200	eath (Check only o					
on of	ling Phys After this funeral di	tion; To	1 ☐ Yes 2√√No  27. Manner of Death  1X√Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Ye	2 X ER/Outpaties 28b. Time of Injury	of 28c. Inju	4   Nursing		dence 6 Other (Sp how injury occurred	pecify)			
Division	To the Hospitel or Attendi within 24 hours efter death. To the Funeral Director: A completely filled in by the fu	Certification;	3 Suicide 6 Could not b 4 Homicide determined		- At home, farm, st Specify)	reet, factory, office		28f. Location (	Street and Number or wn, State)	Rural Route Number,			
	To the Hospitel within 24 hours of To the Funeral completely filled	edicai C	29a. Certifier	nysician: To the best of m niner: On the basis of ex- and manner stated	amination and/or in	h accumed at the ti evestigation, in my o	me, data and place opinion, death occ	te, and due to the curred at the time,	date and place, and d	ue to the cause(s)			
	To th within To th comp	Me	29b. Signature and title of certifier	1. /		29c. Licens	se number		29d. Date signed (Mo	nth, Day, Year)			
•	1.1		30. Name and address of person who	Completed cause of death	My 23a) /Tura	-	0 380.	L 6	10/3	0/06			
	5		Mark King, M.D.	5755 Cedar I		umbia, M	aryland	21044					
	Sta Regist		31. Date filed (Month, Day, Year) NOV 0 1 2	32. Riegistrar's	Signature	code							

State of Maryland / Department of Health and Mental Hygien Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 10 P **Physician** 0410BER 30 2006 /Medical 4a. Facility Name (If not institution, give street 4b. City, Town, or Location of Death Examiner BATIMOLE Under 1 Year If Under 24 Hrs. 6000 SAMARITAN N/A 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1**∑**M 2□F Hours 212-22-9253 Director March 9. 1927 Maryland Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10d. Inside City Limits 10b. County in then "natural", or Items 23a or 28a-f show the Medical Exeminer must be notified at 1 Yes 2 No Directo Maryland Baltimore Co. Carney 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? United States Completed by Funeral 9100 Lamaze Road be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 XX Yes 2 □ No 1951—
If Yes, Give Year or Dates: 1955 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 1 Never Married 2 Married 3 Widowed 4 Divorced Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) mit. Pages 1 and 2 should be filed within sartment of Health and Mental Hygiene. octant: if itsm 27 is marked other than 'injury or other treumatic syent, the Ma Elementary/Secondary (0-12) College (1-4or 5+) 12 Attornev Law 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Francis Michael Burgan Elizabeth Mehling 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Mrs. Norma T. Burgan / Wife 9100 Lamaze Road Carney, Maryland 21234 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) permit. Page Department of Important: if any injury or once. 11/04/2006 Parkwood Cemetery Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Michael E. Canapp 5305 Harford Road Baltimore, MD 21214 Leonard J. Ruck, Inc. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final MYOCARDIAL INFARCTION Physician disease or condition resulting in death) /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Medical Certification: To Be Completed by Physician/Medical Examiner for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Day 5 Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 s has autopsy certificate 2X No completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 3€ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 12 Impatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after deat To the Funerel Director: 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Momicide 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie OCTOB4 & 30, 200 6 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 STOI LOCH RAVEN BLUD BALTIMORE MO 21239 HERBERT m 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 1 2006 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TIEM 10e, 10f, perfH, C861, 11/1/06, WS
State of Maryland / Department of Health and Mental Hygiene
Amend Item 5 per FH, C864, 02/05/07 dhb
Reg. No.

Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death Day Month Year **Physician** BURTON HENRY 21:26 M XTOLER 27 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimure ( If Under 1 Year | If Under 24 Hrs. Hospital Hopkins Johns cty 8. Date of Birth (Month, Day Oct 4 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 100M 20 F Days Months Hours Director 60 Yrs. Usual Residence of Decedent 10a. State 10h Counts 10c. City, Town or Location 10d. Inside City Limits is marked other than "natural", or Items 23a or 28a-f show sumatic event, the Medical Examinar must be notified at 1 Tes 2 No Director MO Baltimore 10e. Street and Number 2029 MCCULLAH ST 10f. Zip Code 10g. Citizen of What Country? USA Funeral Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 □ Yes 2 No 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No δ Specify: 3 ☐ Widowed 4 ☐ Divorced Black Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) filed within Hygiene. Service 10 abover permit. Pages 1 and 2 should be file.
Deperment of Health and Mental Hyg.
Important: If Item 2.7 is marked.
any injury or other? 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Stevens Burton Joseph 19a. Informan's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ton 6852 Parsons Ave Balto, MD evland 20b. Place of Disposition (Name of Date 20a. Method of Disposition 20c. Location - City or Town, State ematory or other place) 1 Burial 2 □ Cremation 3 Removal from State 22. Name and Address of Facility Betts Funeral Home 4 ☐ Donation 5 ☐ Other (Specify) Moryland 21. Signature of Puneral Service Licens 1129 N. Caroline St Baltimore, MD to Micia 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** Cancer \_ una /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine ettending physicien and for use as the burial-transit certificate be executed Due to (or as a consequence of) Box 68760. Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ð 1X Yes 2□No 3 Probabiv 4 □Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? s certiticate has b 1 Yes 2X No 1 Yes 2 No of Vital or Attending Physiclan: director. Be 25. Was case referred to medical examiner? 26. Place of Death Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ 1 ☐ Yes 2 No 1 Inpatient 2X ER/Outpatient 3 DOA this To the mospiner control within 24 hours after death.

To the Funeral Director: After this control tilled in by the funeral control tilled in by the funeral control tilled in by the funeral control tilled in by the funeral control tilled in by the funeral control tilled in by the funeral control tilled in by the funeral control tilled in by the funeral control tilled in the funeral control till 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: Division 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital 1X Certifying Physician: To the best of my knowledge ideath occurred at the films, data and place, and due to the cause(a) and in a nier as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) LWatt MO, PHYSICIAN October 28 RES-000 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar ANDREW WATT, MD

31. Date filed (Month, Day, Year) NOV 0 1 2006

32. Registrar's Signature

Johns Hopkins Hospital 600 N Wolfe St Baltimore MD 21287

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			For State	Sta	te of Maryla	•	rtment of r <i>lificate of</i>		-		2000	34	639
			Registrar  1. Decedent's Name (First, Mid	dle, Last)		007	Theate of	Dealit	2. Date of De			3. Time	of Death
	Physici /8/10dia			Vaon	71 1	Sut	leR		Co tok	Da 201	y Year 30,2000	in	40 AM
	/Medio		4a. Facility Name (If not institut	ion, give street a	nd number)		4b. City, Town, o	or Location of Deat	100		. County of Deal	th	
				ransk			Ba	ltimo	re		N		
	Funeral		5. Social Security Number 215-60-27-61	6. Sex 1 ☐ M 2∫		s. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.		ı <i>v. Year)</i>	9. Birt	hplace (State untry)	e or Foreign
Н	Director		Usual Residence of Decedent		0				Dept 2	4, 1	122 m	laryla	Ln q
	irylan ihow	_	10a. State 10b. Cour	N/A	10c. 0	City, Town or Loc						10d. Inside	
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:	death with the Maryland ms 23a or 28a-f show r must be mulfilled at	Funeral Director	10e. Street and Number	WIK	ens Ar	9	10f. Zip Code	127-9	7	10g. Cit	izen of What Co	ountry?	
	ms 23	eral	11. Marital Status	12. Wa	s Decedent Ever in		as Decedent of H	Hispanic Origin? (S	pecify Yes or No	)-	14. Race - Ame	rican Indian.	
_		F	1 Never Married 2 M	arried 1	ned Forces? Yes 2 No es, Give		_	Hispanic Origin? (S an, Mexican, Puert	o Rican, etc.)		Black, Whit	e, etc.	2
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פ	e filed other vent,	Be C	17. Father's Name (First, Middle	e, Last)	10//			18. Mother's Nan	me (First, Middle	, Maiden	Sumame)		
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F	Physician		Immediate Cause (Final diseas or condition	a	Propuble	Myo	cordial 1	inforction				Onset an	d Death
	/Medical Examiner		resulting in death)	0	oue to (or as a conse	equence of):	- 17						
		ē	Sequentially list conditions,	b. —	CORINAR TUB TO TOT AS A CONSE		ERY D	1515A5B					
	uted d ansit	Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	<b>1</b>									
ρη.	be executed iclan and burial-transit		resulting in death) Last	, <u>D</u>	ue to (or as a conse	equence of):							
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E ,	sici <b>an</b> ; The lav certificate has rector, page 2								perfo 1 ☐ Yes	2 No	death? 1 ☐ Yes	2 🗆 No	
<b>X</b>	Physician; rthis certific ral director,	o Be	25. Was case referred to medie examiner?	Hospital			- Dt	26. Place of Dea			_		
5	r this ar this aral di	<b> -</b>	1 ☐ Yes 2 ☒ No 27. Manner of Death		Date of Injury	_ ER/Outpatient 28b. Time of	3 DOA 28c. Injui Woi	4 Nursing H	ome 5 Resident			city)	
<u>.</u>	ath. r: Afte	atlo	1 Natural 5 ☐ Pend 2 ☐ Accident inve	ding stigation	(Month, Day Year)	Injury		rk?  Yes 2⊡No			•		
DIVISION	r Atte er dea recto by th	Certification;	3 ☐ Suicide 6 ☐ Coul 4 ☐ Homicide dete	d not be rmined 28e.	Place of Injury - At building, etc. (Spec	home, farm, stre	et, factory, office		28f. Location (S		d Number or Ru	ral Route Nu	mber,
בּ	ortal o urs aft ral Di										,		
	To the hospital or Attending Physician; the hospital of attending 24 hours after death.  To the Funeral Director; After this certific completely filled in by the funeral director.	edical	29a. Certifier 15 Certific (Check only one)	al Examiner: On	To the best of my kr the basis of examir d manner stated.	nowledge, death nation and/or inve	occurred at the tile estigation, in my o	me, date and place opinion, death occu	, and due to the rred at the time,	cause(s) date and	and manner as place, and due	stated. to the cause	(s)
	o the o the omple	Me	29b. Signature and title of certi		- State State C.		29c. Licens	se number		29d. Dat	te şigned (Montl	n. Day, Year)	
,	- 5 - 0		Mety		MO		Doc	62634		11	11/06		
	^		30. Name and address of person	n who complete	d cause of death (Ite	em 23a) (Type, P	rint)			/	/		
	V		MATEG	1 AWAT	V 10803	HICKU	RY RID	66 RD	COLU	MBI	A My	210	44
	Sta Registr		31. Date filed (Month, Day, Yea	2006	10803 Registrar's Sign	nature	de						

State of Maryland / Department of Health and Mental Hygien 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 3. 05AM Orsaine October 28,206 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** DSSUS Kose Lane If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. | Mgnth, Day, 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 219-16-5968 1 □ M 2 X E Yrs. **Director** Mass Usual Residence of Decedent filed within 72 hours after death with the Maryland 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other then "neturel", or items 23a or 28e-f show other treumatic event, the Medical Examinar must be notified at oward 1 Yes 2 XNo mdi 1000 **Funeral Director** 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 20794 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Blac 1 ☐ Yes 2 🗷 No Specify: Specify: Completed by 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Pattim and Mental Hygiene.
Is marked other then College (1-4or 5+) Elementary/Secondary (0-12) ustodian Sten 12-11 NIA 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pe permit. Pages 1 and 2 should be Department of Health and Menta Importent: If item 27 is marked any injury or other treumstic events. WILEY 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural R. Lee Number, City or Town, State, Ze Code) 34 Jessup, md. OSE 26794 dayatter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Surial 2 Cremation 3 Removal from State Nov. 6,200 Batto. Battimine Nat'L \*4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Furjaral Service Licenses 22. Name and Address of Facility 270 FredHILTON Vary rimarchianeras Home beeto, mo 23a. Part. Effer the disease, or complications that caused the d ath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) MALICINANT NEOPLASM **Physician** months /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of Completed by Physician/Medical Examiner The law requires that the death certificate be executed use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy for in the past 12 months? Day Month 4☐Pregnant at time of death 5 Other (specify) page 2 should be detached 9 Unknown 9 Unknown þ signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 Probably 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed 1 ☐ Yes 2 ☐ No 2 1 No or Attending Physicien: filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 🗷 Residence 6 ☐ Other (Specify) 1 Yes 2 No Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after deatl To the Funerel Director: 6 Could not be 3 🗌 Suicide 28e. Płace of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 2680 tober 31,2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21042 9051 BALTIMORE NATIONAL PIKE STE 4C SABA SHEIKH M.D 31. Date filed (Month, Day, Agistrar's Signature 2006 Registrar

Pages 1 and 2 should be filed within 72 hours after death with the Maryland 21215-0036  Pages 1 and 2 should be filed within 72 hours after death with the Maryland 21275-0036  Pages 1 and 2 should be filed within 72 hours after death with the Maryland 21275-0036  Pages 1 and 2 should be filed within 72 hours after death with the Maryland 21275-0036  Pages 1 and 2 should be filed within 72 hours after death with the Maryland 21275-0036  Pages 1 and 2 should be filed within 72 hours after death with the Maryland 21275-0036  Pages 1 and 2 should be filed within 72 hours after death with the Maryland 21275-0036  Pages 1 and 2 should be filed within 72 hours after death with the Maryland 21275-0036  Pages 1 and 2 should be filed within 72 hours after death with the Maryland 21275-0036  Pages 1 and 2 should be filed within 72 hours after death with the Maryland 21275-0036  Pages 1 and 2 should be filed within 72 hours after death with the Maryland 21275-0036  Pages 1 and 2 should be filed within 72 hours after death with the Maryland 21275-0036  Pages 2 and	1 Security Number 6. Sex 10-9853 6. Sex 10-9853 10-9855 10-985	2. Was Decedent Ever in Armed Forces? 1	16a. Dec (Gingle Mecha)  19b. Ma 292.  Ob. Place of Discembery, company, co	If Under 1 Year Months Days  Location  River  10f. Zip Code 21220  3. Was Decedent of If Yes, specify out 1 Yes XXNo cedent's Usual Occupe kind of work don NoT use retirement.	Hispanic Origin? (State of Specify:  upation eduring most of worked)  18. Mother's Named Edna Contest and Number or Rule.	pecify Yes or No p Rican, etc.)  king  ne (First, Middle ncetta &	10g. Citizen of What C	ath  MOFE  Intholace (State or Foreigner)  YLand  10d. Inside City Limit  1   Yes 2   W
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tmmed	Part: Epin the disease, or complic hock of heart tailure. List only one diate Cause (Final soor condition	eations that caused the cause on each tine.	death. Do not e	enter the mode of d	ying, such as cardiad	or respiratory a		Approximate Interval Between Onset and Death
Examiner  Sequence of a particular sequence of	intiatly list conditions, leading to immediate Enter Underlying (Disease or injury titated events ng in death) Last	Due to (or as a cor	nsequence of):	Arken	hmias g dis	en .		in-kn
death cer death cer as a stor use siclan/M	MALE: 23 Vas decedent pregnant to the past 12 months?  Yes 2 No	3c. tf yes, outcome of pr 1 □ Live birth 2 □ 4 □ Pregnant at time 9 □ Unknown	Fetal death	3 ☐Ectopic pregnar 5 ☐ Other (specify)			23d. Date of d Month	delivery Day Year
bartill.  bartill.  bartill.  bartill.	Other significant conditions conto	tributing to death but no	at resulting in the	e underlying cause	given in Part I.	-	tobacco use contribute Yes 2 \( \text{No} \) No 3 \( \text{S} \):	to the cause of death Probably 4 Eunkn
Record The law requir ate has been s page 2 should Completed	Uninary B	slodder	C	ancer	•	perf	formed? death'	autopsy findings avail to completion of cause ? es 2 No
Vital Figure 1 The Contribution of the Contrib	as case reterred to medical				26. Place of De			
ding Physician: After this certific funaral director. To Be 10.: To Be	aminer?  Yes 2000  anner of Death  Natural 5 Pending	ospital: 1 Impatient  28a. Date of Injury (Month, Day Yes	2 ER/Outpa	Ment 30 DOV	Other: 4 Nursing Financy at Work?		sidence 6 Other (Sp how injury occurred	pecify)
Division of tall or Attending P tall or Attending P is after death.  Set after death.  Set of the funara definition of the funara of the funar	Accident investigation  Suicide 6 Could not be determined	28e. Place of Injury - building, etc. (S	At home, tarm,		☐ Yes 2☐No		(Street and Number or own, State)	Rural Route Number,
Divisio  To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completaly filled in by the ti  Medical Certificati	(Check only 2 Medical Examin	witing. To the best of money: On the basis of exa	amination and/o					
To the P complete	Signature and title of certifier	and manner stated.		29c. Lice	ense number	4	29d. Date signed (Mo	onth, Day, Year) -2006
30. Na	ame and address of person who co	empleted cause of death	1 (Item 23a) (Ty	rpe, Print)  BAST 1	ERN B	LUD.	M.D -2	1221.

		•	For State Registrar	State of Maryland		artment of H			giene ()	06 34642
	Physici	an	1. Decedent's Name (First, Middle, Last)					2. Date of Dea	ath	3. Tipe of Death
	/Medic Examin	al	Emelia Elsie Chapl  4a. Eacility Name (If not institution, give s			4b. City, Town, or	Location of De	00101	4c. County n/a	of Death
	Funeral Director		216-54-2045		st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 H Hours M		h y, Year)	9. Birthplace (State or Foreign Country) Maryland
	the Maryland 28a-f ehow	Director	Usual Residence of Decedent  10a. State 10b. County  Maryland Baltimore  10e. Street and Number		Town or Lo				10g. Citizen of W	10d. Inside City Limits 1 □ Yes 2 ☑ No
ي	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. ie marked other then "naturel; or Iteme 23a or 28a-f ehow aumatic event, the Medical Examinational be notified at	Funeral	403 Shade Tree Pla  11. Marital Status  1 Never Married 2 Married	Ce, Apt. C  12. Was Decedent Ever in U.S Armed Forces?  1  Yes 2 No If Yes, Give	1	21228 Was Decedent of H f Yes, specify Cuba	ispanic Origin?	(Specify Yes or No erto Rican, etc.)	Blac	e - American Indian, k, White, etc. : White
515-003	rithin 72 hours ne. hen "naturel", e Medical Exe	Completed by	3 X Widowed 4 □ Divorced  15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	Year or Dates: cation completed) College (1-4or 5+)	16a. Deced (Give life. L	tent's Usual Occupi kind of work done o OO NOT use retired	ation during most of v	vorking	16b. Kind of Bu	siness/Industry
/land 2	be filed tal Hygi d other event, I	9	6 17. Father's Name (First, Middle, Last) Edward Vogel	0	Home	maker		lame (First, Middle, da Hummel		Home e)
Baltimore, Maryland 21215-0036	permit. Pages 1 end 2 should Department of Heelth and Men Important: if item 27 ie marke any njury or other traumatic 0000		19a. Informant's Name/Relationship (Ty)  E. Elsie Chaplain  20a. Method of Disposition  1- Burial 2 Cremation 3 Br 41 Donation 5 Other (Specify)	/ Daughter	403 S ace of Dispo		e Place	Date	Catonsv 20c. Location -	State, Zip Code) ville, Md. 2122 City or Town, State ore, Maryland
Balti	Departit Departit Importa any nju		21. Signature of Funeral Service Deense	98						lome, Inc. Maryland 21229
8760,	Physician   Medical   Physician and   Physician and   Physician and   Physician   Physicia	dical Examiner	23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, flay, leading to immediate cause. Enter Underlying Cause (Disease or injury that intitated events resulting in death) Last	Due to (or as a consequence to (or as a consequence).	SHOC ence of): ON I A	Ì	g, such as card	iac or respiratory ar	rest,	Approximate Interval Between Onset and Death  A AV
O. Box 68	re wires that the death certificate be executed en signed by the ettending physicien and could be detached for use as the burial-transitions.	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	3c. If yes, outcome of pregnan 1 □Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown	death 3□	Ectopic pregnancy Other (specify)			23d. Date Mor	e of delivery nth Day Year
ords, P.	w requires that it becauses the signed by should be detailed to the signed by the should be detailed to the signest the signest that it is should be detailed to the signest the signest that it is should be detailed to the signest the signest that it is should be detailed to the signest that it is should b		Part II. Other significant conditions con  CORONARY ART			nderlying cause giv	en in Part I.	23e. Did to		ribute to the cause of death?  3 Probably 4 Unknown
Division of Vital Records,	The law ste has b page 2 si	Completed			-			1 ☐ Yes	osy primed? d	Vere autopsy findings available prior to completion of cause of leath?  Yes 2 No
<u>=</u>	ysicla is certi	To Be	25. Was case referred to medical examiner?	ospital: 1 ☐ Inpatient	R/Outpatien	nt 3□ DOA Oth	oc.	Death <i>Check only o</i> THome 5 Resid	77	er (Specify)
sion o	To the Hospital or Attending Physician: The I within 24 hours effer death. To the Funerel Director: After this certificete ha completely filled in by the funeral director, page	Certification: 7	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	(Month, Day Year)	28b. Time of Injury	M 1 🗆		28d. Describe l	now injury occurr	ed
<u>N</u>	spital or At ours effer dierel Directilled in by		4 Homicide determined	28e. Place of Injury - At hor building, etc. (Specify)	) 		no, date and nic	City or Tox	vn, State)	er or Rural Route Number,
٠	To the Hos within 24 h To the Fun completely	Medical	(Check only one)  2 Madical Examination  29b. Signature and title of certifier	nar: On the basis of examinati and manner stated.	on and/or in	vestigation, in my o	pinion, death or	ccurred at the time,	date and place, a	and due to the cause(s)  (Month, Day, Year)
	ĺ		30. Na wand address of person who	mpleted cause of death (Item	23а) (Туре,	D 22	-6 Y F	(	October	30, 2006 ND 21229
	Sta Registi		Jerone Saya 31. Date filed (Month, Day, Year)	32. Registrar's Signatu	uTH C	ATON AVER	vue BAL	TIMERE,	MBRYLE	ND 21229

ÖRIGINAL

			For State Registrar	State of	Marylar	nd / Depa	artment of F	lealth and		giene 006	34643
			Decedent's Name (First, Middle,	Last)	-		timeate of	Dealin	2. Date of Dea		3. Time of Death
	Physici /Medic		DAVID	M C	CLA	RK	7	R	DCT	Day 200	6 1241 PM
	Examin		4a. Facility Name (If not institution,	•	,	., -	4b. City, Town, o			4c. County of Dea	
		-	HOWARD COUN  5. Social Security Number		SRAL   7. Age (In yrs.	HUSPIT	Il Under 1 Year	UCUM!		How	
Н	Funeral Director		220949018	100M 2□F	4	f / Yrs.	Months Days	Hours M	in. (Month, Day	3 1965	rthplace (State or Foreign ountry)
	D .		Usual Residence of Decedent  10a. State 10b. County		100 0	ty. Town or Lo		<del></del>	7777		
	Aaryle	ŏ	MD Howa	- nd	100.01						10d. Inside City Limits 1 ☐ Yes 2 🖾 No
	28e-	Director	10e. Street and Number	11 U		Laurel	10f. Zip Code		-	10g. Citizen of What C	
	h with	a D	10725 Scaggsv	ille Road			21	0723		USA	
	deat	ner	11. Marital Status	12. Was Deced	dent Ever in U	.S. 13.			(Specify Yes or No- erto Rican, etc.)		
36	or Ite	by Funeral	1 Never Married 2 Marrie	d 1 ☐ Yes 2 If Yes, Give	2 No No	1		Specify:	eno rican, etc.)	Black, Wh  Specify: W	
21215-0036	hour	ed p	3 ☐ Widowed 4 ☐ Divorced  15. Decedent's	Year or Date	tes:	16a Dece	dent's Usual Occup	ation		16b. Kind of Business	
215	hin 72 nn "nn Medic	Completed	(Specify only highest Elementary/Secondary (0-12)		4or 5+)	(Give	kind of work done of NOT use retired	during most of w	vorking	Teb. Kind of business	windustry
7	ed with	Com	12th	Ø	401 017	Car	penter			Construc	ction
gug	ould be filed within 72 hours after death with the Maryland Mental Hygiene. Inted other than "natural", or items 23e or 28e-f ahow afte avent, the Medical Examinar must be notified at	Be	17. Father's Name (First, Middle, La David Michae	,	Con				lame (First, Middle,		
2	should and Men a marke umatic	은	19a. Informant's Name/Relationshi		Sr.	10h Mailie	na Address (Street		istine Fer	guson r, City or Town, State.	T- 0- 4-1
<u>8</u>	nd 2 s lith an 27 ia r trau		Christine Clark	-	er		•		pad, Laure		
Baltimore, Maryland	permit. Pages 1 and 2 should be filled within 72 hours after death with the Marylen Department of Health and Menth Hygiene. Important: If tem 27 is marked other than "natural", or liems 23s or 28e-f show any injury or other traumatic event. Its Marical Examinar must be notified at once.		20a. Method of Disposition		20b. F	Place of Dispo	sition (Name of natory or other place	1	-	20c. Location - City of	
<u>Ĕ</u>	Page ment c ant: if ury or		1 ABurial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe		IAIB		UM Churc	1	/27/2006	Laurel, MI	)
3alt	ermit. Depert Inport ny Inj IDCE.		21. Signature of Funeral Service Li	bensee						Funeral HO	Dme, P.A.
	40 E 4 0	-	23a. Part 1. Enter the disease, or c	molications that as	M001				ue, Laurel		
	Dhusisian		shock, or heart failure. List of	nry one cause on ea	ch line.				ac or respiratory arr	est,	Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)		r as a conseq		OPATT	17			20 YEARS
	Examiner		Sequentially list conditions,	b							
16	pe #s	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (a	r às à conseq	uerice of).					
 /	and al-tran	хап	that initiated events resulting in death) Last	c. Due to (o	ras a conseq	uence of):					
8760,	The law requires that the death certificate be executed tie has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	dlcal		d							
9	rtifical ng phy as th	Medi	IF FEMALE:								
Вох	leath certifi attending for use as	lan/	23b. Was decedent pregnant in the past 12 months?		th 2 ☐ Feta	ildeath 3□	Ectopic pregnancy			23d. Date of de Month	livery Day Year
o O	that the de led by the a detached f	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4∐Pregnai 9□ Unknov	ntattime of d vn	leath 5□	Other (specify)			IN GHE	Day Feat
ت. ص	igned by be deta	by Ph	Part II. Other significant condition	s contributing to dea	ith but not res	ulting in the ur	nderlying cause give	n in Part I.	23e. Did tol	bacco use contribute t	o the cause of death?
Records,	w require been sig should b								1 □ Y	es 2 1 No 3 □ P	robably 4 Unknown
မင္မ	e law re has be je 2 sho	Completed							24a. Was a		utopsy findings available completion of cause of
_									perform 1 Tes	med? death? 2 No 1 □ Yes	
Vita	Physician: r this certifica ral director, i	o Be	25. Was case referred to medical examiner?  1 Yes 2 No	Hospital:		50.0	of pos Othe	-	eath (Check only of		
o	ng Phys ter this neral di	$\vdash_{\mathbb{N}}$	27. Manner of Death	28a. Date of (Month,		ER/Outpatien 28b. Time of	t 30 DOA 28c. Injury Work	4 Li Nursing		ence 6 Other (Spe	icify)
<u>0</u>	uttending I death. ctor: After y the funer	atlo	1 ☑ Natural 5 ☐ Pending investiga	tion	, Day Year)	Injury		(? Yes 2 □ No			
Division of	or Att	Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	ad 289. Place 0	I Injury - At ho g, etc. (Specify	ome, larm, stre	eet, factory, office		28I. Location (St City or Town	reet and Number or R n, State)	ural Route Number,
	Hospitel or Attanding 4 hours effer death. Funeral Diractor: Afte tely filled in by the tune		29a. Certifier 17 Certifying	Physician: To the t	est of my kee	uuladaa daath				ause(s) and manner a	
	To the Hospitel or At within 24 hours effer of To the Funeral Direct completely filled in by	Medical	(Check only 2 Medical Ex	aminer: On the bas	is of examina	tion and/or inv	restigation, in my of	pinion, death oc	ce, and due to the ca curred at the time, d	ause(s) and manner as ate and place, and due	s stated. a to the cause(s)
	To the within 2 To the comple	Ž	29b. Signature and title of certifier	0 . 1	1.		29c. License	0-1		9d. Date signed (Mont	
	10		bend L	eicliff	h	MD.	02	788	8	DCT 24	12006
	17		30. Name and address of person with 5450 KW0		of death (Item		Print) VE C	olum	BIA N	DCT 24	145
	Sta		31. Date liled (Month, Day, Year)		gistrar's Signa		South !			, 0	70
	Registra	ar	MONOT	2000	series .	15 /6/	A STATE OF THE PARTY OF THE PAR				

			For State	State of Ma	arylan					and M	ental Hy	giene	אחה	34644
			State     Registrar  1. Decedent's Name (First, Middle, La)	n#1		С	ertificat	e of L	Death	т	2. Date of De	Reg. No.	_000	
	Physici		i. Decedents Name (First, Middle, La	51)							Month	eath Day	Year	3. Time of Death
	/Medio		Paul Joseph Char 4a. Facility Name (If not institution, giv	e street and number)			4b. City,	Town, or	Location o	of Death	Octob	er 30	ounty of Death	12:36 PM
	, ? * h Binness at a second	10	Gilchrist Center 5. Social Security Number 6. S	for Hosp	ice (	are	av) If Under	1 Voor	#ONES	on	0 Date - ( D)	Be	altimor	e
h	Funeral Director		1	M 2□F 7. A9		<i>last birthd</i> Yrs	Months	Days	Hours	Min.	8. Date of Bir (Month, Da	ay, Year)	9. Birth Cou	place (State or Foreign intry)
	0		Usual Residence of Decedent  10a. State  10b. County		5.6	. T					10/19	9/1950	) MD	
	daryla f shov ed at	ō	Toa. State Tob. County			y, Town or								10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	Director	MD Baltim 10e. Street and Number	ore	Mi	ddle	River 10f. Zip	Code				10g. Citize	en of What Cou	
	th with		35 Widmonland Dr											
	er dea items	Funeral	35 Hydroplane Dr 11. Marital Status	Armed Forces?		.S. 1	3. Was Decei If Yes, spe	dent of Hi cify Cuba	spanic Orig n, Mexican	gin? (Spec , Puerto F	cify Yes or No Rican, etc.)	USA 12	1. Race - Ameri Black, White	
39	al", or	by	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 □ Yes 2 □ If Yes, Give Year or Dates:	No		1 🗆 Yes	2 <b>2</b> No	Specify:			s	Specify:	
21215-0036	72 hou natura ilcal E	Completed	15. Decedent's Ed (Specify only highest gra	ucation de completed)		16a. De	cedent's Usu	al Occupa	ation	of workin	-	16b. Kind	d of Business/Ir	ite ndustry
12	vithin "ne. han "	mple	Elementary/Secondary (0-12)	College (1-4or 5	5+)	·	ive kind of wo e. DO NOT us	se retired	)	OI WOIKIII	g	Pri	nting	
	filed v Hygie other t	ပ္ပ	17. Father's Name (First, Middle, Last,			Pla	ate Mal	er	18. Mother	r's Name	(First, Middle	. Maiden Si	urname)	
Maryland	lid be fental rked o	To Be	Joseph Francis C											
ary	2 should and Men is marker aumatic		19a. Informant's Name/Relationship (			19b. Ma	ailing Address	(Street a			Anna_St Route Numb		Town, State, Zi	p Code)
	1 and 2 Health tem 27 I		Rose Chaney		look r	35	Hydro	plan	e Dri				, MD 21	
Baltimore,	Pages hent of		20a. Method of Disposition 1 ☐ Burial 2 🗷 Cremation 3 ☐		200. F	emetery, o	sposition (Nar crematory or d	ther plac	e)		Nov 1	20c. Loca	átion - City or T	own, State
븚	nit. Partme ortani Injun		4 ☐ Donation 5 ☐ Other (Specify 21. Signature of Funeral Service Licer	·	C	hesap	eake C 22. Name an	rema d Addres	tory is of Facility		2006	Belt	sville,	Maryland
ä	permit. Departimonts any inj		Hyada Such	the Mo	Alu-	2	Cmama				l Alter	nativ	es	
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	olications that caused one cause on each li	I the deat	h. Do not	enter the mod	e of dying	g, such as	ures cardiac or	<b>Drive</b> respiratory a	Baltin rrest,	more, Ma	Approximate Interval Between
gg .	Physician		Immediate Cause (Final disease or condition resulting in death)	a. leter	1 4 1	10 c	elle	la	19 (		cin		- 1	Onset and Death
4	/Medical Examiner		Toolaing in docari,	Due to (or as	a conseq	uence of):								
D.	髮	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as	a conseq	uence of):								
W	scuted nd transit	Examiner	triat iritiated everits	c										
8760,	cate be executed oblysician and the burial-transit	EX	resulting in death) Last	Due to (or as	a conseq	uence of):								
687	ficate physics the	Physician/Medical	•	d										
Box	h certi ending use a	M/u	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1 ☐ Live birth			3□Ectopic pr					23	d. Date of deliv	ery
B	e deat he attr	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at			5 ☐ Other (sp						Month	Day Year
P.O.	The law requires that the death certificate be executed to has been signed by the attending physician and page 2 should be detached for use as the burial-transit		9 ☐ Unknown  Part II. Other significant conditions of		ut not resi	ulting in the	e underlying c	ause nive	n in Part I		23e Did t	obacco use	contribute to t	he cause of death?
Division or Vital Records,	uires i signe	d by		3				,					,	bably 4 ☐Unknown
S	aw requir s been si 2 should	olete									24a. Was			opsy findings available
<u>~</u>	The lay ate has page 2	Completed									auto perfo	psy prmed? 2 No	death?	ompletion of cause of 2 □ No
Vita	iclan: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:				Tou.		of Death	(Check only o			
9	Phys rthis ral dir	2	1 Yes 2 No	1 ☐ Inpatie		ER/Outpat 28b. Time	tient 3 DC		4 LI Nur		e 5 Resi	_	Other (Speci	W) Hozna
Ö	nding F th. r: After e funera	ation	1 Natural 5 Pending 2 Accident investigation	(Month, Da		Injur	у м	8c. Injury W <i>o</i> rk 1	? ∕es 2∐N		od. Describe	now injury c	occurred	
NIS.	or Attending Physiclan: ufter death. Director: After this certifica in by the funeral director, p.	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of inju- building, etc	ury - At ho	ome, farm,	street, factory	, office		28	Bf. Location (		Number or Run	al Route Number,
	pital o urs aft eral Di											,		
	To the Hospital or Attending Physiclan: The within 24 hours after death.  To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Medical	29a. Certifier 1 ☐ Certifying Ph (Check only one) 2 ☐ Medical Exar	ysician: To the best niner: On the basis of and manner sta	f examina	wledge, de tion and/o	eath occurred r investigation	at the tim , in my op	ne, date and pinion, deat	d place, a th <i>o</i> ccurre	nd due to the d at the time,	cause(s) ar date and p	nd manner as s lace, and due t	stated. o the cause(s)
	To the within To the Compl	Me	29b. Signature and title of certifier	1 2				. License				29d. Date s	signed (Month,	Day, Year)
			1/ Buth	Mily	· u	On	1	2	520	DO		Oct	Lober	30,200€
	3		30. Name and address of person who	6/		23a) (Typ	pe, Print)	10	6.0	7	1 0	11	mi	30, 200 E
	Sta	te.	31. Date filed (Month, Day, Year)	32. Registra	1 ( ar's Signa	ture	9 -		inc	0	11 7	COUNT	- 104	ce cox
	Registr		NOV 0 1 200		1	1	mark!							

			1 - For State Registrar	State of Ma	aryland / Dep <i>Ce</i>	artment of H				ene 006	34645
	Dhyoini	o	1. Decedent's Name (First, Middle, Li	ist)				1.	. Date of Death Month	Day Year	3. Time of Death
	Physici /Medic		Dora Ellen Cull					0	clober	29, 200	6 5:40 AM
6.	Examin	er	4a. Facility Name (If not institution, gi	. 11		4b. City, Town, or	1 -			4c. County of Deat	
				ing Home	e (In yrs. last birthda)	Havre (	If Under	race	. Date of Birth	Harfa	
	Funeral Director			1 □ M 2 □ XF	Vrc	Months Days	Hours	Min.	(Month, Day, Y		hplace (State or Foreign untry)
	ס		Usual Residence of Decedent		78 "			17.7	ar. 23,	1928 Virg	ginia
	nrylan how	_	10a. State 10b. County		10c. City, Town or I	ocation					10d. Inside City Limits
	Be-f	Funeral Director	Maryland Harf	ord	Stree						1 ☐ Yes 2√2 No
	with th		10e. Street and Number			10f. Zip Code			100	g. Citizen of What Co	untry?
	eath ne 23	era	1252 Trappe Road	12. Was Decedent	Ever in II S 12	21154 Was Decedent of H		inin? (Consid	fu Vos er Ne	USA 14. Race - Ame	door ladion
	fter d	E	1 Never Married 2 Married	Armed Forces?		If Yes, specify Cuba	an, Mexicar	n, Puerto Rio	can, etc.)	Black, White	
93	al', o	ρ	3. 2 Widowed 4 □ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 🙀 No	Specify:			Specify: Whi	+0
2-0	be filed within 72 hours after death with the Maryland at Hygiene. All the Wadleal Esandher hat the notiliad at event, the Madleal Esandher has the notified at	Completed	15. Decedent's E (Specify only highest gi		16a. Dec	edent's Usual Occup e kind of work done	ation	t of working	16	Sb. Kind of Business/	
2	within ne.	ig m	Elementary/Secondary (0-12)	College (1-4or 5	life.	DO NOT use retired	1)				
2	iled v Tygia ther t		17. Father's Name (First, Middle, Las	*)	Hom	emaker	19 Moths	arie Niama /6	First, Middle, Ma	Own Home	2
and	d be f ental h	o Be	Murphy (unk) He							Boatwright	
ary.	should ind Men marke umatic	ပ္	19a. Informant's Name/Relationship		19b. Mai	ing Address (Street a			·	City or Town, State, 2	
ž	end 2 ealth a m 27 is		John Cullum/ Son							Maryland 2	
ore,	ges 1 and 2 should be filed within 72 hours after death with the Marylan it of Healin and Mental Hygiens. It filed may be and Mental Hygiens. It filed 27 is marked other then, "natural," or flems 23a or 28e-f ehow or other traumatic event, the Mudical Examiner must be notified at		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 [	7.D	20b. Place of Disc			Date		c. Location - City or	
Ĕ.	Pag ment ent: f ury o		4 □ Donation 5 □ Other (Special	fy)	Calvary	UM Church		11-01-	-06 Cl	nurchville	, Maryland
Baltimore, Maryland 21215-0036	permit. Pages 1 end 2 Department of Health s Importent: If Item 27 is eny injury or other tra		21. Signature of Fune of Service Lice	May .	M	CCOMAS Fu	ss of Facilit	Home.	. P. A.	n, Marylan	
	au = • a		23a Part1. Enter the disease, or con	Car 2	1 1	317 Cokes	bury	Rd., 1	Abingdor	n, Marylan	
			23a Part1. Enter the disease, or con shock, or heart failure. List only Immediate Cause (Final	one cause on each lir	n the death. Do not el	A	g, such as	cardiac or re	espiratory arres	ι,	Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a corun Mi	y mueny	VITERSE					
Н	Examiner			Must	a/consequence of):	Thi Dost	DAT	RMMI	m/		
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as	a consequence of):	10/	1,10	0 1-11110	10		
	ransii	Examiner	that initiated events	· DIABOTE	5 MELLITH	5			_		
90,	e exection a	EX	resulting in death) Last		a consequence of):	MING					
8760,	The law requires that the death certificate be executed tie has been signed by the attending physician and age 2 should be detached for use as the burial-transit	dical	•	d CAM PI	NASHIM	(pulla)					
9 X	that the death certific ed by the attending p detached for use as	Physician/Me	IF FEMALE:	23c. If yes, outcome	of pregnancy					23d Data of dali	
Вох	death atter	clar	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No		2 Fetal death 3	□Ectopic pregnancy □ Other (specify)				23d. Date of deli Month	Day Year
<u>Р</u> О	oy the achec	hysi	9 Unknown	9□ Unknown							
S,	res tha igned I	by P	Part II. Other significant conditions	contributing to death be	ut not resulting in the	underlying cause give	en in Part I.		23e. Did toba	cco use contribute to	the cause of death?
ord	w require been si should b	ted	Demorily						1 ☐ Yes	2 □ No 3 □ Pro	obably 4 Unknown
ecc	e law r has be ge 2 sh	Completed		<del> </del>					24a. Was an autopsy	24b. Were au	topsy findings available
		Con							performe	d2/ death?	2 No
Zit Zit	ilclen certifi rector	Be	25. Was case referred to medical examiner?	Hospital:		- Don Othe		of Death	Check only one		
ō	Phys r this saldi	. To	1 ☐ Yes 2 ☑ No 27. Manng⊷of Death	1 Unpatie	nt 2 ☐ ER/Outpatie	nt 3 DOA	4V NU		5 Residence  Describe how	ce 6 Other (Specinium occurred	nfy)
ö	nding tth. r; Afte e func	tion	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injui (Month, Da)	Yeer) Injury	Work	k? Yes 2 ∐ I			.,.,	
Division of Vital Records,	ar deg	Certification;	3 ☐ Suicide 6 ☐ Could not to determined		ury - At home, farm, s	reet, factory, office		28f	Location (Stree City or Town,	et and Number or Ru	ral Route Number,
۵	ital or A irs after ral Dire	Cer									
	To the Hospital or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director,	Medical	29a. Certifier 1 ♥ Certifying P (Check only one)  2 ■ Medical Exe	nysicien: To the best of miner: On the basis of and manner sta	examination and/or i	th occurred at the tim nvestigation, in my op	ne, date an pinion, dea	d place, and th occurred	due to the caus at the time, date	se(s) and manner as a and place, and due	stated. to the cause(s)
1	To the h within 24 To the F complete	Σ	29b. Signature and title of certifier			29c. License	number	2/	29d	Date signed (Month	
	*		1/1/20/ 9/1	1		1)4	VII			10/30/06	
	10		30. Name and address of person who	ZIS /	A	/ 241	n	2/02/	6		
	Sta	te	31. Date filed (Month, Day, Year)	/	MON M ar's Signature	VC MI	1/	101	9		
	Registr		MOV D 1 2006	Brancia D	& Sperke						

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		4	For State Registrar	State of Marylan		artment of H rtificate of L			Reg. No.	006	34646
81		_	Decedent's Name (First, Middle, Las	1)				2. Date of Dea Month		Year	3. Time of Death
	Physicia /Medic	1.00	BENJAMIN	COLEMAN					27,2	006	6:30A M
	Examin	100 (8)	4a. Facility Name (If not institution, give			,	Location of Death		4c. C	County of Death	1
	- 18 M		GOOD SAMARITA  5. Social Security Number 6. Se		last birthday)	B. If Under 1 Year	ALTIMORE If Under 24 Hrs.	8. Date of Birt	h	N/A 9. Birth	nplace (State or Foreign untry)
	Funeral Director			M 2□F 76	Yrs.	Months Days	Hours Min.	(Month, Day	y, Year)	30N.C	AROLINA
	D P		Usuaf Residence of Decedent  10a. State 10b. County	10c. Cit	y, Town or Lo	cation					10d. Inside City Limits
	death with the Maryland ms 23s or 28s-f show r nust be notified at	٥	MD. N/A			IMORE					1 X Yes 2 □ No
	r 28e-	Director	10e. Street and Number			10f. Zip Code			10g. Citiz	en of What Co	untry?
	h with	a D	420 E. OLIVER	STREET		2120	2			ISA	
	or Items 23a	Funeral	11. Marital Status	<ol><li>Was Decedent Ever in U. Armed Forces?</li></ol>	.S. 13.	Was Decedent of H If Yes, specify Cuba	ispanic Origin? (Spe an, Mexican, Puerto I	cify Yes or No Rican, etc.)	- 1	<ol> <li>Race - Amei Black, White</li> </ol>	
20		by Fu	X Never Married 2 Married 3 Widowed 4 Divorced	1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates:		1 ☐ Yes 2√ No	Specify:		3	Specify: BL	ACK
2-003o	72 hours "natural", ulcal Ex		15. Decedent's Ed	ucation	16a. Dece	dent's Usuaf Occup	ation during most of workii	na	16b. Kin	d of Business/	industry
213	within 7: ene. then "n	Completed	(Specify only highest gra	Colfege (1-4or 5+)	life.	DO NOT use retired	during most of working	ng .			
Z	filed wi Hygien ther th		7TH		I	ABORER	18. Mother's Name	/First Middle	BGE Maiden		
and	be d ital	Be	17. Father's Name (First, Middle, Last) ASA COLEMAN				CALENA				
5	s 1 and 2 should F Health and Men Itam 27 ie marke other traumatic	P.	19a. Informant's Name/Relationship (7	Type, Print)	19b. Maili	ng Address (Street	and Number or Rura	il Route Numbe	er, City or	Town, State, 2	lip Code)
Mar	alth ar 27 io 17 io		FRANCENNA COLI	EMAN(sister)			VER ST.			MD.	21202
c,	es 1 a of Hea fitam rothe		20a. Method of Disposition 1√2 Burial 2 ☐ Cremation 3 ☐	Permoval from State	Place of Dispo cemetery, crea	osition (Name of matory or other place	NOV.	ate 2006	20c. Loc	cation - City or	
altimore,	Page ment ant: fi		4 Donation 5 Dother (Specify	- 14				MS CE	м о	WINGS	MILLS,MD.
Ball	permit. Pages Department of Important: If It eny injury or o		21. Squature of Funeral Service Licen	7/ Kings	C	2. Name and Addre	ss of Facility SCRUGG ERESTON	S FUN	ERAL	HOME	21213
	8 1		23a. Part1. Enter the disease, or com- shock, or heart failure. List only	plications that caused the deat	h. Do not en	ter the mode of dyir	ng, such as cardiac o	or respiratory a	rrest,	21 M	Approximate Interval Between
A	Physician		Immediate Cause (Final disease or condition		mynco	ndial	in Garch	on			Onset and Death
	/Medical Examiner	3	resulting in death)	a. Acre A  Due to (or as a conseq  b. (ononce	uence of):	1	0.				C
	Lammer	16	Sequentially fist conditions, if any, leading to immediate	b. Ononce	y valuence of):	Antery	Die	1017			8 4
7	ted nsit	Examiner	Cause (Disease or injury	22000	,						
a î	execting and and rial-tra	Exal	that initiated events resulting in death) Last	Due to (or as a consec	quence of):						
68760	ficate be executed physician and is the burial-transit	edical	(	d							
	- P		IF FEMALE:	23c. If yes, outcome of pregn.	ancv				1	3d. Date of del	ivon
Вох	eath certiff attending I for use as	clan	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 Feta	al death 3(	☐Ectopic pregnance	у			Month Month	Day Year
P. O.	the d	Physician/M	1 Yes 2 No 9 Unknown	9 Unknown							
a. G	The law requires that the death certi tie has been signed by the attending page 2 should be detached for use a	by P	Part If. Other significant conditions of		sulting in the t	underlying cause giv	en in Part I.				the cause of death?
g	w require been si			la be bes				1	Yes 2L	JN0 3[]Pr	obably 4 Unknown
e C	alawr has be e 2 sh	Completed	Brain mass	· Close	242	respira 1	forg	24a. Was		24b. Were at prior to death?	topsy findings available completion of cause of
a H	r: The		failure					1 Yes	2 2 40		2 No
<u> </u>	siciar certif irecto	o Be	25. Was case referred to medical examiner?  1 Yes No	Hospital: 1 ☐ Inpatient 2	ER/Outpatie	ent 3 DOA Ct	26. Place of Deatl			Other (Soe	cilv)
ō	Attending Physician: or death. ector: After this certification.	n: To	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time o			28d. Describe			,
ior	andin sath. or: Aft	atlo	1 Accident 5 Pending investigation	n			Yes 2 □No				•
Division of Vital Records,	or Atte	Certification:	3 Suicide 6 Could not be determined		nome, farm, si ify)	treet, factory, office		28f. Location ( City or To	(Street and wn, State)	j Number or Ri	ural Route Number,
	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2			nysicien: To the best of my kn							
	he Ho in 24 t he Fu pletely	edical	one)	niner: On the basis of examin and manner stated.	ation and/or it			red at the time,			
Y	With To t	Σ	29b. Signature and title of certifier	1		29c. Licen:				e signed (Mont	
h	XI	Ì	Daniel 12	Cenun of			43386		10	0.30-06	· 
	) ' '		30. Name and address of person who	/ Howa-d,	ന 23a) (Type ഗ	21 N. F	whow HL	405 B	es.	nem as	1 21217
1	St	ate	31. Date filed (Month, Day, Year)	32, Registrar's Sign	ature		<u> </u>				- F
20	Regist		NOV 0 1 2006	R. K	brech						

DHMH 17 Rev 1/2001

ORIGINAL

			For Stata	State of Maryl	and / D	epartmer <i>Certifica</i> i	nt of H te of I	ealth an Death	id Ment		jiene leg. No.	006	34647
	1 104	P.,	Registrar  1. Decedent's Name (First, Middle, La.	st)		- Continuation	.0 01 2	204111		ate of Dea	th		3. Time of Death
П	Physicia /Medic		BETTY J.	DONNEL	LY				M	lonth O	Day 27	Year OG	
	Examin	_	4a. Facility Name (If not institution, giv					Location of C			4c. 0	County of Dea	ath
	1 4 9		GOOD SAMARI	<del></del>				rimo				NA	
15	Funeral Director		212201810	ex 7. Age (In	yrs. last birtl	rs. If Unde Months	Days	If Under 24 Hours	Min. (A	ate of Birth fonth, Day	(Year)	C	rthplace (State or Foreign country)
	and w		Usual Residence of Decedent  10a. State 10b. County	100	. City, Town	or Location							10d. Inside City Limits
	Mary f ehc	to	Md. NA		Bal	timore							1 ŽiYes 2 □ No
	r 28a	Director	10e. Street and Number			10f. Zi	p Code			1	10g. Citiz	en of What C	Country?
	deeth with the Maryland ims 23a or 28a-f ehow rintit be notified at		609 Winston Aven	ue			2121	2				USA	
	tems	Funeral	11. Marital Status	12. Was Decedent Ever Armed Forces?	in U.S.	13. Was Dece	dent of Hi	spanic Origin n, Mexican, P	? (Specify Y	es or No- , etc.)	1	4. Race - Am Black, Wh	erican Indian, ite, etc.
36	filed within 72 hours after deeth with the Marylan Hygiene. the than "naturel", or Items 23a or 28a-f show ent, the Medical Examinat must be notified at	by Fi	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 No If Yes, Give Year or Dates:		1 ☐ Yes	<b>¾</b> No	Specify:				Specify:	Black
1215-0036	"naturel",		15. Decedent's E	ducation	16a.	Decedent's Usu	ial Occupa	ation			16b. Kin	d of Busines:	
212	be filed within 72 ho tal Hygiene. d other than "natur event, the Medical	Completed	(Specify only highest gra Elementary/Secondary (0-12)	College (1-4or 5+)		(Give kind of wi life. DO NOT L	ork done d ise retired	during most of )	f working				
	filed wit Hygiene ther the	Com	12th grade			Sorter	:				Wes	tingho	use
Maryland 2		Be	17. Father's Name (First, Middle, Last) Walter		nnelly	,		18. Mother's		t, Middle,		,	
2	should be nd Mental marked c	2	19a. Informant's Name/Relationship (			Mailing Addres	n (Strant)	Ann		to Mumba		rown	Tin Code)
Σ	s 1 and 2 should f Health and Mer ltem 27 is marke other traumatic		Durran Topp, Jr.	Son		09 Wins						2121	
altimore,	s 1 ar f Hea ftern 3		20a. Method of Disposition	20		Disposition (Na.	CONTRACTOR CONTRACTOR	Control of the Contro	Date				r Town, State
Ë	Pages nent of int: if it ury or o		1 ☐ Burial 2√Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif	Themoval Holli State	_	mount C		ı	1-3-06	5	Bal	timore	. Md
Balti	permit. Pages Department of Important: if It eny injury or o		21. Signature of Funeral Service Licer	Therefore	1	22. Name a	nd Addres	ss of Facility  orth A	Mar	ch F	.н.	East	21202
4			23a. Part1. Enter the disease, or com	plications that caused the	death. Do n							,	Approximate
	Physician		shock, or heart failure. List only Immediate Cause (Final	one cause on each line.	1 10	· taca.	m. A	mic.	100	)			Interval Between Onset and Death
Ä.	/Medical		disease or condition resulting in death)	a. Due to (or as a cor	nsequence of	Intra	ieni	BI CIL	LUL,	)			
П	Examiner		Sequentially list conditions	b. Hyp.	erten	eion							
Ä	pg tr	Iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a cor	nsequence o	f):							
_	and and Il-tran	Examiner	that initiated events resulting in death) Last	c. Due to (or as a cor	nsequence o	fi:							1
68760,	ificate be executed g physician and as the burial-transit		l	d		,							
89		edlcal		d									
Вох	death certifi e ettending id for use as	an/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pr		3 □Ectopic p	regnancy				2	3d. Date of de	
O. E	0 0 0	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐ Pregnant at time 9☐ Unknown		5 Other (s						Month	Day Year
مـ	that the		Part II. Other significant conditions	contributing to death but no	t resulting in	the underlying	causa divi	en in Part I.		23e. Did to	bacco us	se contribute	to the cause of death?
Division of Vital Records,	The law requires that the tee bas been signed by this page 2 should be detache	Completed by		creatitis							′es 2□	_	Probably 4 Unknown
ecc	as be	plet							_ 2	24a. Was a		24b. Were a	autopsy findings available completion of cause of
<u> </u>		Соп							1	perfor Yes	med?	death?	
Vita	Physicien: Th this certificate al director, pag	Be	25. Was case referred to medical examiner?	Hospital:			Oth	0.00	Death Che				
0	Phys	: To	1 Yes 2 No 27. Manner of Death	28a. Date of Injury	2 ER/Out 28b. T			4 140121		5 Resid		Other (Sp	ecify)
on	th. : After s funer	tlor	1  Natural 5  Pending 2  Accident investigatio	(Month, Day Yea		njury M	28c. Injury Work 1 ☐	k? Yes 2 ☐ No			,,	00001100	
N N	Attender death	Certification:	3 Suicide 6 Could not b	e 28e. Place of Injury - building, etc. (S)	At home, far	m, street, factor	y, office		28f. L	ocation (S	street and	Number or F	Rural Route Number,
	Ital or rs afte al Dir led in	Cert	Tomole	building, etc. (3)	овспу)					nty or row	n, Siate)		
	To the Hospital or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certifics completely filled in by the funeral director,	Medical	29a. Certifier 1 ☐ Certifying Pl (Check only 2 ☐ Medical Example)	nijsician: To the best of my niner: On the basis of exa and manner stated.	knowledge mination and	death unsumed For investigation	at the tion	a data and pinion, death	occurred at	na to thair the time, o	date and	place, and du	ue to the cause(s)
	To the To the To the Comp	ž	29b. Signature and title of certifier	L 1. 0	10 7		c. License			4	29d. Date	signed (Mor	nth, Day, Year)
			Bharner	Kaun P	6 Y-I		RES	000			( D	127/1	06
	2		30. Name and address of person who	completed cause of death	13	Type, Print)		imar	. 1 ~		11		Lal
1	Sta	te	31. Date filed (Month Ray, Year)	32. Registrar's S	Signatura	00		imar	TY	1)	1	USP	Tal
	Registr		MONDIS	UUD AND STATE OF THE STATE OF T	J.	STATE OF ALL	No.						

34648 State of Maryland / Department of Health and Mental Hygien [ ] [ ] [ Certificate of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Year 10:33am Physician Lois Elaine Durm 10 06 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FRANKLIN oseda Age (In yrs. last birthday) HIMORE Lake If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Jan. 30, 1931 Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Days Min. Hours 1 □ M 2 🛛 F 75 217 28 0297 Director Pennsylvania Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b. County filed within 72 hours after death with the Marylar Hygiene. other than "natural; or Iteme 23a or 28a-f ahow ent, its Madical Examinar mant he notified at 1 ☐ Yes 2X No Maryland Baltimore Essex Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1900 Grove Manor Dr. "Apt. 403" 21221 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 22 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Specify: White 21215-0036 1 ☐ Yes 2X No Specify: δ 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Electronics Assembler permit. Pages 1 and 2 should be filed will Department of Health and Mental Hygient Important: If item 27 is marked other that any injury or other traumatic event, 136, 2008. 12 Electronics Mfq. Maryland 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Floyd G. Hite Mary Miller 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stephen David Miller (Nephew) 11445 Woodland Drive Felton, Pennsylvania 17322 Itimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from State Holly Hill Mem. Gardens 10/31/2006 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signafure of Funeral Service Licenses Bruzdziński Funeral Home P.A. Holm 1407 Old Eastern Avenue Essex, Maryland 21221 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Shoo Deptic disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner IRinany tract infection Secuentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a cons uence of): burial-transit The law requires that the death certificate be executed and resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physicien for use as the buria by Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day 4 Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☑ No the page 2 should be deteched 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 🔀 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an certificate has autopsy performed? 1 Yes 2 🔯 No funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death | Check only one Hospital: 1 ☑ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 ☑ No 2 ER/Outpatient 3 DOA After this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: 28b. Time of or Attending 5 Pending 1 Natural death. 1 ☐ Yes 2 ☐ No 2 Accident investigation the Director: 3 Suicide 6 Could not be determined Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide within 24 hours a To the Funeral C Hospital cai 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one 29d. Date signed (Month, Day, Year) 29c. License numbe 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9000 FRanklin Sq. Samantha dR. Baltimore, MD Q1237 DREVER 900( 32. Registrar's Signature

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

NOV 0 1 2006

URM

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 005 34649 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month **Physician** Ida May Dressel October 28, 2006 2:25 A. M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Catonsville Baltimore Manor Care Nursing & Rehab If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🖾 F 216-22-4117 Director 89 Nov.12, 1916 Maryland Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits ehow item 27 is marked other than "naturel", or itema 23a or 28a-f ebor other traumetic event, the Mcdical Examinar must be notified at 1 ☐Yes 2 No Directo Maryland | Baltimore Windsor Mill 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1 Berlee Court 21244 USA death \ Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel", or iter eny injury or other traumetic event, the Modical Exemplical ORGE. 1 ☐ Yes 2 K No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White þ Specify: 3 ☑ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 6 Machinist Stee1 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Herman H. Ruoff Edna A. Connors ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joseph H. Drasal, Sr. 1 Berlee Court; Windsor Mill, MD 21244 Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 □ Removal from State 4 □ Donation | 5 □ Other (Specify) edeemer 11/1/2006 Baltimore, Maryland
22. Name and Address of Facility Sterling Ashton Schwab Witzke
Funeral Home of Catonsvill, Inc. <u>Holy Redeemer</u> 21. Signature of Funeral Service Licensee ebea 1630 Edmondson Avenue: Catonsville, MD 21228 23a. Part1. Ent if the disease, if complications that shock, or heart failure. Lift only one cause on ear the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician EREBROVAS CULAR resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner attending physicien and < death certificate be executed resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No detached ф 9☐ Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by should be 3 Probably 4 Dunknown DIABETES MELLITU 1 ☐ Yes 2 ☐ No peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has page 2 autopsy performed? certificate 2 No director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No မှ 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Certification; 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident

Division of Vital Records, P.O. Box 68760. s after death. filled in by To the Hospital o within 24 hours af To the Funeral D completely filled in

> State Registrar

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Medical

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29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

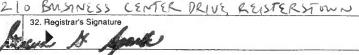
3 Suicide

29a. Certifier

4 Homicide

6 ☐ Could not be

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

10-31-2006

1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D0059107

State of Maryland / Department of Health and Mental Hygiene, 34650 1 - For State Registrar Reg. No. Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) October **Physician** Barbara Virginia Edwards 26,2006 5:54PM M /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince George's Clinton 6306 Clinton Way If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month. Day Aug. 17 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Funeral Days Min. Hours Country) Vi<u>rginia</u> Months 1 ☐ M 2 🗓 F 56 Yrs. 226-72-6886 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b County 1 ☐ Yes 2 N No Clinton Prince George's Director Maryland 10g. Citizen of What Country? 10f Zio Code 10e. Street and Number U.S.A. 20735 6306 Clinton Way Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, 11 Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married African 1 ☐ Yes 2 ☑ No Specify: Specify þ 3 Widowed 4 Divorced American Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Billing Medica1 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lucille Hi11 Randall Brown 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 6306 Clinton Way Clinton, Maryland 20735 DOFF Edwards (Husband) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Nov. 1 ₺ Burial 2 Cremation 3 Removal from State Powhatan, Virginia Brown Family Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 2006 22. Name and Address of Facility Lee Funeral Home, Inc. 21. Signature of Funeral Service Licenses 6633 Old Alexandria Ferry Road Clinton, MD 20735 10rus voran MO0257 Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. olon Cancer Immediate Cause (Final M**Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine Division of Vital Records, P.O. Box 68760, CO In or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): attending physicien a for use as the burial-Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 ponths? Day Month Year 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown ete has been signed by page 2 should be detact 23e. Did tobacco use contribute to the cause of death? Part It. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ No 3 Probably 4 Unknown 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificete 1 ☐ Yes : After this certifice e funeral director, f To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one Be examiner' No Other: 4 Nursing Home Residence 6 Other (Specify) Certification: To 1 Yes 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) Manner of Death 28b. Time of 28d. Describe how injury occurred Natural 5 Pending 1 Tes 2 No 2 Accident investigation Director: filled in by the 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours after To the Funerel Direct 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and maintenance.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Dey, Year) Woodyard Road #201 8926 cause of death (Item 23a) (Type, Print) addres 20735 31. Date filed (Month, Day, Year) 32. Refistrar's Signature State NOV 0 2006 Registrar

			State of Ma	ryland / Dep					34651
			Registrar	Ce	rtificate of L	Jeath		. N2006	,
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	/Medic	al		ANS	# 02 T	1	OCTUBER	28 2006 4c. County of Death	
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			5. Social Security Number 6. Sew 7. Age	(In yrs. last birthday	If Under 1 Year	OH/SCE/ If Under 24 Hrs.	8. Date of Birth	9 Righ	place (State or Foreign
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	yland		10a. State 10b. County	10c. City, Town or L	.ocation				10d. Inside City Limits
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	d within 72 hours after death with the Maryland jiene. Then' naturel', or iteme 23a or 28a-f show the Madical Examinational be notified at	Funeral Director	2208 Siena Way		21.	163		U.S.A.	
	dea - dea	ner	11. Marital Status 12. Was Decedent E Armed Forces?	ver in U.S. 13.	Was Decedent of Hi If Yes, specify Cuba	ispanic Origin? (Spo n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ameri Black, White,	
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Maryland	should be nd Mental marked o	<b> -</b> -	19a. Informant's Name/Relationship (Type, Print)					City or Town, State, Zij	
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5			20a. Method of Disposition 1 🛣 Burial 2 □ Cremation 3 □ Removal from State	20b. Place of Disp cemetery, cre	osition (Name of ematory or other place	(e)	Date 20	Oc. Location - City or T	own, State
Ĕ	Pages nent of ant: If it ary or o		4 Donation 5 Other (Specify)	Fore	st Lawn	11/3,	/06 R	ichmond,	VA
Baltimore,	permit. Page Department of Important: If eny injury or once.		21. Signature of Funeral Service Licensee	. м	22. Name and Address arch F/H	ss of Facility West			
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			23a. Part1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each lin	the death. Do not er e.	nter the mode of dying	g, such as cardiac	or respiratory arres	it,	Approximate Interval Between Onset and Death
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ŏ	eath certific attending pl for use as t	Z	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of					23d. Date of deliv	өгу
<b>m</b>	A 00 A	Completed by Physician/Mec	in the past 12 months?  1  Yes 2  No		☐ Ectopic pregnancy ☐ Other (specify)			Month	Day Year
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<u>~</u>	hysician: The law his certificate has b I director, page 2 s	Con	CORTES CONGESTIVE	Hany	Fr. hunz	=	perform 1 Yes 2	ed? death?	2 No
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Ĕ		i,	27. Manner Teath 28a. Date of Injur (Month, Day	y 28b. Time Year) Injury	Worl	y at k? Yes 2 □ No	28d. Describe how	/ injury occurred	
Sign	ttend death tor: the t	cat	2 Accident investigation 3 Suicide 6 Could not be 389 Place of Init	ury - At home, farm, s			28f Location (Stre	eet and Number or Rur	al Route Number
Division of Vital	after Direction by	ertification;	4 Homicide determined building, etc		street, factory, office		City or Town,	State)	ar riodio ridinosi,
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: Attercompletely filled in by the funer	O	29a. Certifier 1 Certifying Physician: To the best of	of my knowledge, dea	ath occurred at the tin	ne, date and place.	and due to the cau	use(s) and manner as	stated.
	• Ho 24 h • Fu	edicai	(Check only 2 Medical Examiner: On the basis of and manner sta	examination and/or i	investigation, in my o	pinion, death occur	red at the time, dat	e and place, and due t	o the cause(s)
	To the within 2 To the comple	×	29b. Signature and title of certifier		29c. License	e number	29	d. Date signed (Month,	Dey, Year)
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	12		30. Name and address of person who completed cause of de	ath (Item 23a) (Type		RANDAL	WEST	Hospiral	- Con Con
	10		ORCHNGO B. CONTA	That re	2	RANDAL	STOWN	Marylan	0 21133
	Sta		31. Date filed (Month, Day, Year) 32 Registra	ar's Signature	CARL				
	Regist	ar	NOV 0 1 2006	- 1					

Certificate of Death 1. Decedent's Name (First, Middle, Last 2. Date of Death Earl Francis Fletcher Month **Physician** October 29, 2006 9:10 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll 2029 Rudy Serra Drive, Apt. 2B Eldersburg 5. Social Security Number 216–16–8591 If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1**⊠** M 2□ F 82<sup>Yrs.</sup> Director June 16,1924 Maryland Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at Maryland Carroll Eldersburg 1 ☐ Yes 2 XNo Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2029 Rudy Serra Drive, Apartment 2B 21784 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠ Yes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Give kind of work done during most of working life. DO NOT use retired) 1 and 2 should be filed within Health and Mental Hygiene. em 27 is marked other than College (1-4or 5+) 5+ Elementary/Secondary (0-12) Railroad carman Railroad 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Waldo Fletcher Gladys Perrier or other traumatic 19a. Informant's Name/Relationship (Type. Print)
Elizabeth Mary Fletcher/Wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2029 Rudy Serra Drive, Apt. 2B, Eldersburg, MD 21784 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Loudon Park Cemetery 11/03/2006 Baltimore, Maryland 4 Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hubbard Funeral Home, Inc. 21. Signatur of Funeral Service Licensee 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** END Stage disease or condition resulting in death) 10 years /Medical Due to (or as a consequence of): Examiner Asbestusin Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner burial-tran resulting in death) Last Due to (or as a consequence of): the attending physician hed for use as the buria Physician/Medical 23b. Was decedent pregnant in the past 40 NA 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death NIA 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown 9 Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 3 ☐ Tobably 4 ☐ Unknown 1 Tes 2□ No Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a, Was an autopsy performed? Yes 2 No 1□ Yes funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 5 ☐ Pending investigation 1 Natural 1 Tyes NIA 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) H0057710 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6190 GEORGETOWN BLUDERS BURG MD FOLDEN, m.D. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 2006 NOV 01 DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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ennis Shawn F		igan State 1- For State	of Maryland / D	epartment of Certificate of			Mental	Hygiene			
Physicia		R <mark>egistrar</mark> 1. Decedent's Name (First, Middle,La		Certificate	Ji Deali			2. Date of De	Reg. No.	200	3 Time of Death 5
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e, MD 21215-0036 I and 2 should be filted within 72 hours after death with the Maryland Heath and Mental Hygiene item 27 is marked other than "natural", or items 23a or 28a-f she rerammatic event, the Medical Examiner must be notified at once	Be		Omer T. Flan	agan, Jr.			Do	rothy Ec	kard	l	
O 21 should nd Me is ma	٩	19a. Informant's Name/Relationship (Sean Flanagan	Type, Print )	19b. Mail	ing Address	Street a	and Number of	r Rural Route N	umber, C	City or Town, State	Staff, AZ.
and 2 shou lealth and b tcu 27 is n traumatic		20a. Method of Disposition		20b. Place of Disp	osition (Nar	me of ceme	eterv.	Date		Location - City or	
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- 1		or condition resulting in death)	Due to (or as a conseque	ence of):							
	je	Sequentially list conditions, if any, leading to immediate	Due to (or as a conseque	ence of):							
W	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseque	ence of):							
xecurest n and i - transit	al E		ı. <u> </u>								
15 5 G		UNPENDED	AMENDED								
Box 68760, edath certificate be the attending physical for use as the buried for use as	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome o		Fetal death	3	Ectopic pre	nancv	23	3d. Date of deliver Month	y Day <b>Y</b> ear
ox 687 eath certific attending	icia	past 12 months?	4 Pregnant at time		Other (Spe						- 4,
. Bc he dea y the a	hys	1 Yes 2 No 9 Unknow  Part II. Other significant conditions	9Onknown	t not soculting in th	o undodvina		en in Bort I	22e Did	Ltobacco	use contribute to	the cause of death?
Division of Vital Records, P.O. Box 68760, in 24 hours after death certificate be hin 24 hours after death. The law requires that the death certificate be the Funeral Director. After this certificate has been signed by the attending physici pipletely filled in by the funeral director, page 2 should be detached for use as the buri	by	Tart ii. Other significant conditions	contributing to death bu	t not resulting in th	e underlying	g cause giv	en in Pait i.				bably 4 Vulknown
rds, require been si	Completed						•	24a. Wa			utopsy findings available
of Vital Records, ng Physician: The law require Wher this certificate has been si meral director, page 2 should t	mpl							_ per	opsy formed?	death?	completion of cause of
tal Rec rian: The certificate ector, page	ပိ	25. Was case referred to medical				26.Place o	of Death (Che	Later and the same of the same	5 2 1	No 1 ✓ Y	es 2 No
Vita hysicia this ce	o B	examiner? 1 ✓ Yes 2 No	Hospital: 1 Inpatient	2 ER/Outpatie	ent 3 E	00A  0	ther Nu	sing Home 5	Resid	ence 6 🗸 Othe	er: Scene
n of ing Pt After Tuneral	T:T	27. Manner of Death	28a. Date of Injury (Month, Day, Year) FOUND:	28b. Time o	of Injury .	28c. Injury		28d. Describ Unknown	e how in	jury occurred	
Sior Mttend death. ctor:	atic	Natural 5 Pending Accident Investiga	tion Oct 21, 2006	0000 hrs		L,41	es 2 V No				
Division pital or Attendir ours after death. eral Director: Affilled in by the fu	Certification:	3 Suicide 6 ✓ Could no determin			reet, factory	, office bui	ilding, etc.	or Town	, State)		ural Route Number, City
Tospit 4 hour Funera ely fill	ပိ	29a. Certifier	cian: To the best of my kn		curred at the	time, date	and place, a			n Avenue, Cu	
Division To the Hospital or Attend within 24 hours after death To the Funeral Director:	edical		er:On the basis of examina and manner stated.								
To with	Me	29b. Signature and title of certifier	2	- 17	290	c. License				. Date signed (Mo	
		('ard	- Hell	llev		O.C.M	l.E.		Oc	tober 22, 200	6
7		30. Name and address of person who Carol Allan, MD Assist	completed cause of death		Street	Baltimor	re, MD 21:	201			
	ate	31. Date filed (Mortal Day, Year)			, Gacet,	-	10, IVID 21.				
	State 31. Date filed (Morty) 1941. Y 1971 1 2006 Registrar  32. Registrar's Signature										

State Registrar Name and address of person who

NOV 0

1 2006

31. Date filed (Month. Day, Year)

HGHWAY ANNAPOLISMD 21401

mpleted cause of death (Item 23a) (Type, Print)

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TAM

			1- For Amend item#16a, perFH, 0861, 11/8/06 Te Registrar Co	artment of Health and Martificate of Death	lental Hygie Reg.	2006	34655
	4		1. Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year	3. Time of Death
	Physici /Medic		John Thomas Gormican			27, 2006	19:15 ™
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
+			Calvert Memorial Hospital	Prince Frederi	ick	Calvert	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda)	Months Days Hours Min.	8. Date of Birth (Month, Day, Ye	ear) Cou	
	Director		236 46 6204 1 TAM 2 F 74 Yrs.		Aug 25,	1932 West	Virginia
	and w		10a. State 10b. County 10c. City, Town or I	ocation			10d. Inside City Limits
	Mary	į	Maryland Calvert Duni	kirk			1 ☐ Yes 2√∑ No
	the rout	Director	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Cou	ntry?
	h with		9914 Joathan Drive	20754	J	Jnited Sta	tes
Maryland 21215-0036	d within 72 hours after death with the Maryland jene. r than "natural", or Itams 23a or 28a-f show the Madical Exa cities must be inclifted at	by Funerai	11. Marital Status  1 Never Married  2 X Married  1 Never Married  3 Widowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 X Yes 2 No Korean If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (Spalf Yes, specify Cuban, Mexican, Puerto  1 ☐ Yes 2☐ No Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ameri Black, White, Specify:	
Ą	2 hor	ted	15. Decedent's Education 16a. Dec	edent's Usual Occupation	166	. Kind of Business/In	
215	hin 7	Completed	(Specify only highest grade completed) (Giv Elementary/Secondary (0-12) College (1-4or 5+)	e kind of work done during most of worki DO NOT use retired)	ng		
21	T 70 5 5	Ω		S. Navy and Air Force	2	Military	
p		Be (	17. Father's Name (First, Middle, Last)	18. Mother's Name	(First, Middle, Mai	den Sumame)	
yla		To	Francis Xaxier Gormican	Gertrud			
lar.	2 sho land l			ling Address (Street and Number or Rura			Code)
	s 1 and 2 should of Health and Mer item 27 Is marks other traumatic			Joathan Drive, Du		20754 Location - City or To	Oura Stata
altimore,	Pages nent of h int: if ite		Mag Donai 2 Dolamation 3 Diremoval nom State	osition (Name of matory or other place) Nov 21,			
弄	it. Partmer			n National Cemeter		lington, V	Virginia 💮
Ba	permit. Pages Department of I Important: If its any injury or of		FUTTO MULTOY	2. Name and Address of Facility Lee 6633 Old Alexanderi	a Ferry R	load Clint	
			23a art1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.	nter the mode of dying, such as cardiac o	r respiratory arrest,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)  a. Ventricular	- Fibrilloti	on		Crisci and Death
	/Medical Examiner		Due to (or as a consequence of):			1.	
		er		tic Cardio vo	ymlar	disease	
RI.	nsit	nin	cause. Enter Underlying Cause (Disease or injury				
D.	be exacuted sician and burial-transit	Examin	that initiated events c. Due to (or as a consequence of):				
,0928	cate be exacuted ohysician and the burial-transit	dicai	<b>C</b> d				
9		0					
O. Box	The law requires that the death certificate has been signed by the attending orge 2 should be detached for use as	Physician/M		□Ectopic pregnancy □ Other (specify)		23d. Date of delive Month	ery Day Year
Δ.	s that ned b e deta	by P	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacc	co use contribute to the	he cause of death?
rds	quires in sign uld be	pa pa	Severe Mitral Regurgi	tation.	1 🗆 Yes	2□No 3 Prot	pably 4 Unknown
Vital Records,	aw requir s been si 2 should	ompieted	severe comonic obstruction		24a. Was an	24b. Were auto	psy findings available
æ	The lav	E O	Preumonia.	1 -11-10-10-10-10-10-10-10-10-10-10-10-10-	autopsy performed 1 ☐ Yes 2 ☑	l2 death?	mpletion of cause of
ita		Se C	25. Was case referred to medical	26. Place of Death		10 103	2010
<b>†</b>	S S	To B	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatie	ent 3 DOA Other: 4 Nursing Hor	ne 5 Residence	e 6 □Other (Specif	(y)
n of	ding Ph h, After th funeral		27. Manper of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day Year) Injury Injury		28d. Describe how i		
Si	ttendil death, tor: A the fu	atic	2 Accident investigation	M 1 ☐ Yes 2 ☐ No			
Division	or Att	ertification;	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	treet, factory, office	28f. Location (Street City or Town, St	t and Number or Rura tate)	d Route Number,
	urs af	0		<u> </u>			
	To the Hospital or Attending within 24 hours after death. To the Funeral Diractor: After completely filled in by the funer	edical	29a. Certifier (Check only one)  1 ✓ Cartifying Physician: To the best of my knowledge, dea 2 ☐ Medical Examiner: On the basis of examination and/or is and manner stated.	th occurred at the time, date and place, a nvestigation, in my opinion, death occurre	and due to the cause ed at the time, date	e(s) and manner as s and place, and due to	tated. of the cause(s)
)	with To I	M	29b. Signature and title of certifier  Legum. C	29c. License number D 50653		Date signed (Month,	
	10 X		30. Name and address of person who completed cause of death (Item 23a) (Type 5851 - Deale Church.		SUPAN	A MD	20751
	Sta	- 1	31. Date filed (Month, Day, Year) 32. Registrar's Signature	**************************************			/
	Registr	ar	NOV 0 1 2006	soft.			

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ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item 5 per fh e863 1-12-07 vt
State of Maryland / Department of Health and Mental Hygiene Reg. No. 2006 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Christine Gamble 10 29 2006 4:50p. M /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Gilchrist Nursing Home Towson Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. | O 4 Month, Pay, Year 36 5. Social Security No 24 6. Sev 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Months 1 □ M 2 🔏 F 242-60-941 70 Yrs. NC Director Usual Residence of Decedent 72 hours after death with the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show 7 is marked other than "natural", or Items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at 1 DYes 2 No Director MD NA Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1760 Carswell Street 21218 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes No If Yes, Give Year or Dates: 14. Bace - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 □ Yes 2 No Specify. Specify: Black þ 3X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72 Department of health and Mental Hyglene. Important: If Item 27 is marked other than "nat any Injury or other traumatic event, the Medica once. (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th grade Unit Clerk Sina Hospital 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Harvey Brown Francis Price 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Nelson R. Gamble-Son 2303 Rogate Circle, Baltimore, Md 21244 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) King Memorial Park 11/4/06 Randallstown, Md 21. Signature of Funeral Service Licensee Ma lace and for the officient 4300 Wabash Ave, Baltimore, Md 21215 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. yeur Immediate Cause (Final **Physician** disease or condition resulting in death) +€ /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate caus. Enter the carrying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine sician and The law requires that the death certificate be executed Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) detached 9 Unknown 9 ☐ Unknown signed b 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s has autopsy certificate 1□ Yes 2⊡No director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA 2 this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Hospital or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident Director: 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide after within 24 hours aft To the Funeral Di completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical To the Fun 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29d. Date signed (Month, Day, Year) October 30, 200 ( 29c. License number 29b. Signature and title of certifier 025205

State Registrar

31. Date filed (Month, Day, Year)

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DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

2. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print). Charles of Bolto md 2020

State of Maryland / Department of Health and Mental Hygiene 34657 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day Nellie Gatton 28, 2006 4c. County of Death /Medical October 2006 3.15 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 249 Trappe Road Dundalk Baltimore Co. 8. Date of Birth (Month, Day, Year) May 25,1917 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) North Carolina **Funeral** Months 1 ☐ M 2 🛛 F 89 Director 240-12-1133 Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23s or 28s-f show other trsumatic event, the Madical Examinar must be notified at 1 ☐ Yes 2X No Director Maryland Baltimore Co. Dundalk 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? filed within 72 hours after death with 21222 United States 249 Trappe Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. Black, White, etc. 1 ∏Yes 21∑No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 þ 1 Yes 2 XNo Specify: Specify: 3X Widowed 4 □ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 8 Years permit. Pages 1 and 2 should be file Department of Heelth and Mental Hy important: If item 27 is marked othe any injury or other traumatic event, suce. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Ida Eliot John Eubanks ည 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 804 Gary Drive Kingsville, Maryland Linda L. Zegal (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State ¥∆Burial 2 Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) Garrison Forest V.A. Cem. 11/3/2006 Owings Mills, MD 21. Signature of Funeral Service License 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 23a. Part1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or head failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause Final disease or condition resulting in death) Arrest **Physician** (ardiac /Medical Due to (or as a consequence of): Examiner oronaex Aster Dinease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner To the Hospital or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of) P.O. Box 68760, physicien Physician/Medical the IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 🗙 No the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. \$ cate hes been sig page 2 should b 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death | Check only one Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No ٩ this 27. Manner of Death 28a. Date of Injury (Month, Day Year) After t Medical Certification: 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 Pending death investigation 1 TYes 2 No within 24 hours after death
To the Funeral Director:
completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[Insertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and manner as stated.

[Insertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D002185 10.30-0% 8 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 23, SHIPPING A Baltimore MD MOHAMMAD TA DIMD 2. Registrar's Signature 31. Date filed (Month, Day, Year) State NOV 0 1 2006 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Beverly V. 28, 2006 Green October 4:45 p. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Gilchrist Center Towson Baltimore Co. 8. Date of Birth (Month, Day, Year) June 11, 1 If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Months Hours 1 □ M 2 🙀 F 89 218-09-9944 Director Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland r 28a-f show notified at 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 XYes 2 No Director Maryland N/A Baltimore 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code Hygiene. other than "natural", or items 23a or " the Medical Examiner must be r 6216 McClean Blvd. Funeral 21214 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 3 Widowed 4 Divorced 1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates: Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White Be Completed by permit. Pages 1 and 2 should be filed within 72 ho Depatrment of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Maryland State Elementary/Secondary (0-12) College (1-4or 5+) Librarian 12 yrs.
17. Father's Name (First, Middle, Last) Dept. of Education 18. Mother's Name (First, Middle, Maiden Surname) V. Lauman Arthur L. Mvers P 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Harry K. Green / Husband 6216 McClean Blvd. Baltimore, MD 21214 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 XBurial 2 □Cremation 3 □Removal from State 4 □Donation 5 □ Other (Specify) 11/02/2006 Baltimore, Maryland Moreland Mem. Park 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 5305 Harford Road u.acc. Baltimore, MD Leonard J. Ruck, Inc. 21214 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Sepsis Syndrome **Physician** week /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner law requires that the death certificate be executed burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical the attending ph I for use as t IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has performed2 2 No 25. Was case referred to medical examiner? filled in by the funeral director, 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Hospital or Attending 5 Pending investigation 1 Natural death. 1 ☐ Yes 2 ☐ No 2 Accident after death 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 hor To the Fune 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) uno 4 and address of person who completed cause of death (Item 23a) (Type, Print) N. Chules St. Balto and 2:204 31. Date filed (Month, Day, 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

			1 - For State Registrar		partment of Health and N	lental Hygie	2006 346	59
		. rep	Registrar  1. Decedent's Name (First, Middle, La.		ertificate of Death	Reg.		
- 33	Physici		LE QUIDCY	GANTT		Month	Day Year Cili	
	/Medic Examin		4a. Facility Name (If not institution, give		4b. City, Town, or Location of Death		4c. County of Death	-
*		g-1	MERCY MOSICAL	center	Beltimere		NIA	
***	Funeral		5. Social Security Number 6. S	ex 7. Age (In yrs. last birthda	y) If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, Ye	9. Birthplace (State or Country)	Foreign
36°	Director	1	215 - 76 - 3119	45 Yrs.		June 13	1961 north Carol	ina
	land w		10a. State 10b. County	10c. City, Town or	Location	·	10d. Inside Cit	y Limits
	B-f eh	tor	md N	A Ba	etimore		1 XYes	2 □No
	or 28	Jired	10e. Street and Number	1 / 4 6	10f. Zip Code	10g.	Citizen of What Country?	
	death with the Maryland ms 23a or 28e-f ehow rmust be notified at	rai	528 EI	Latagette are	21262		USA	
5-0036	be filed within 72 hours after death with the Marylar lat Hygiene. d other than "natural", or items 23a or 28e-f show event, the Madical Examiner must be natified at	by Funeral Director	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 22 No If Yes, Give Year or Dates:	<ol> <li>Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto</li> <li>Yes 2 No Specify:</li> </ol>	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.	2
ე- ე-	72 ho	Completed	15. Decedent's Ed (Specify only highest gra	ducation 16a. De	cedent's Usual Occupation ve kind of work done during most of work	ina 16b	Kind of Business/Industry	
2	Mithin ne.	mpl	Elementary/Secondary (0-12)	College (1-4or 5+)	o. DO NOT use retired)	-	Self-empli	rod
א ס	filed v Hygie Ither t	Co	17. Father's Name (First, Middle, Last)	NIA	18. Mother's Name	e (First, Middle, Maid		
<u>a</u>		To Be	Ernest A	att	1:11		m core	
Maryland	d 2 should th and Mer t7 Is marke traumatic	-	19a. Informant's Name/Relationship (	Type, Print) 19b. Ma	tiling Address (Street and Number or Run			
	and 2 Balth an 27 I		Lillian Gantt		* ** ** ***	and the same of th	0, md, 2/202	-
Baitimore,	of H If Item		20a. Method of Disposition 1 Burial 2 remation 3	Actual a	rematory or other place)	Date 20c.	Location - City or Town, State	
			4 □Donation /5 □ Other (Specific	netro	Crematory 1931	106 Ca	tousuite ind	
g	permit. Departr Important any inj		21. Signature Maneral Stylice Licer	nel (	22. Name and Address Pacility 27 Jey Pimare h Fun	eral Home	Secto, md, 212	29
			shopk, of heart failure. List only	plications that caused the death. Do not e one cause on each line.	enter the mode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Betw Onset and D	veen
- (6)	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Myocarsial INF.	DE CTON)		Chist and B	oatii .
	Examiner		-	Due to (or as a consequence of):				
21		Jer	Sequentially list conditions, Tary Loans to inmediate cause. Enter Underlying	b. Due to (or as a consequence of):				
3	cuted nd ransit	Examin	that initiated events	c.				
Ď	e exe sien ar urial-t	EX	resulting in death) Last	Due to (or as a consequence of):				
8760,	icate be executed physicien and the burial-transit	dicai		d				
×		Physician/Me	IF FEMALE:	23c. If yes, outcome of pregnancy			22d Date of deligent	
X POX	death certiff e attending id for use as	iciar	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 Fetal death 3 4 Pregnant at time of death 5	B Ectopic pregnancy Country Other (specify)		23d. Date of delivery  Month Day Ye	ear
S.	t the by the tache	hys	9 Unknown	9□ Unknown				
ecords, r	w requires that the death certif been signed by the attending should be detached for use a	þ	Part II. Other significant conditions of	ontributing to death but not resulting in the	underlying cause given in Part I.		o use contribute to the cause of de 2 □ No 3 □ Probably 4 📜U	ath? nknown
ပ္တ	law rec as bee 2 shor	Completed				24a. Was an	24b. Were autopsy findings a	vailable
I	The laste ha	mo				autopsy performed 1 ☐ Yes 2 ☑ 1	prior to completion of cal death? No 1 □ Yes 2 □ No	use of
Vital	ysicien: The law is certificate has b director, page 2 s	Bec	25. Was case referred to medical examiner?		26. Place of Death	Check only one	10 10 20 10	
=	hy his	P.	1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatient 2 SER/Outpat				
ב	ding Ph. h. After th funeral	ion:	27. Manner of Death 1 ⊠Natural 5 □ Pending	28a. Date of Injury 28b. Time (Month, Day Year) Injury	/ Work?	28d. Describe how in	jury occurred	
DIVISION	Attend death ctor: y the	ficat	2 Accident investigation 3 Suicide 6 Could not be			28f. Location (Street	and Number or Rural Route Numb	10/
$\leq$	afor after	Certification:	4 Homicide determined	28e. Place of Injury - At home, farm, building, etc. (Specify)	stroot, radiory, office	City or Town, Sta	are)	61,
	To the Hospitel or Attending P within 24 hours after death. To the Funeral Director: After to mpletely filled in by the funera	edical (	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	yeician: To the best of my knowledge de niner: On the basis of examination and/or and manner stated.	ath occurred at the time, data and place, investigation, in my opinion, death occurr	and due to the cause ed at the time, date a	(s) and manner as stated. ind place, and due to the cause(s)	
	To the to the To the Complet	Me	29b. Signature and title of certifier		29c. License number	29d. [	Date signed (Month, Day, Year)	
			All M	. B .	P 18594	10	128/2006	
	2		30. Name and address of person who	completed cause of death (Item 23a) (Typ				
	CONTRACTOR N		21 Date filed (Month Day York)	Ph.	SI Bellevier No	5		
	Sta Registr		31. Date filed (Month, Day, Year) NOV 0 1 20	32. Pogistrar's Signature	Land.			
			- 4 M M	MARGERIAN SS AN	1 45 45 L			

DHMH 17 Rev 1/2001

	1	State Amend item#10a-f, peri	of Marylar h,6861,11/	nd / Depa 6/06 <i>Cel</i>	artment of H rtificate of I	lealth and Me Death	ental Hygier Reg.	ne 006	34660
Physiciar	1	Decedent's Name (First, Middle, Last) Agnes Elizabeth	Gall				2. Date of Death	Pax 06 Year	3. Time of Death 1:58 p M
/Medica Examine		a. Facility Name (If not institution, give street and Long View Nursin			4b. City, Town, or Manches	Location of Death		4c. County of Dear Carrol	
Funeral Director	6	Social Security Number 6. Sex 1 M 20 1 M 20	7. Age ( <i>In yr</i> s.	. last birthday) Yrs.			B. Date of Birth (Month, Day, Ye. 14g • 5 • 191	ar) 9. Biri Co Ma:	thplace (State or Foreign puntry) ryland
show		sual Residence of Decedent  Da. State  10b. County  Carro  Vonte		ity, Town or Lo	cation Manch	ester			10d. Inside City Limits
with the Mar		0e. Street and Number 3332 Main St	reet	TOTIK	10f. Zip Code	21102	10g.	Citizen of What Co	buntry?
fiter death w		1. Marital Status 12. Was	Decedent Ever in U	J.S. 13. 1	Was Decedent of H	ispanic Origin? (Spec	ify Yes or No-	U.S.A.	erican Indian,
036 urs after de al., or item	<u>~</u>	1 Never Married 2 Married 1 Yes	d Forces? es 2 ☑-No , Give or Dates:		f Yes, specify Cuba 1 ☐ Yes 2 █ No	in, Mexican, Puerto R Specity:	ican, etc.)	Black, Whit	e, etc. White
Maryland 21215-0036 d 2 should be filed within 72 hours att the and Mental Hygiene. 77 is marked other than "natural", or "traumatic event, it a Michal Exami	Collibrated	15. Decedent's Education (Specify only highest grade complete Elementary/Specondary (0-12)  Colle	ted) ge (1-4or 5+)	(Give		ation during most of working ()	7 16b	. Kind of Business	ŕ
d 21 filed w therth	5	7. Father's Name (First, Middle, Last)		500	retary	18. Mother's Name (	First, Middle, Maid	AAI Cor	0
Vlan	0 0	Joseph Frederick					Myers		
Mary nd 2 sho lith and N 27 is ma	1	9a. Informant's Name/Relationship (Type, Print, Gerald J. Gall –	Son	19b. Mailir 665 I	ng Address <i>(Street a</i> Bairs Rd.	and Number or Rural. , York, Pa	Route Number, Cit	ty or Town, State, 2	Zip Code)
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Talours after death with the Maryland Important: If item 27 is marked other than "natural", or items 23e or 28a-1 show any injury or other traumatic event, it a M-dical Examinat must be notified at once.	Sec. 100	0a. Method of Disposition 1	C1-1-	cemetery, crer	vition (Name of matory or other place Valley Me	em. Oct. 3		. Location - City or imonium ,	
Balti permit. Departi Imports any inju		21. Signature of Funeral Service Licensee	2			ss of Facility Funeral Ch			1102
Pnysician /Medical Examiner		23a. Part1. Enter the disease, or complications t shock, or heart failure. List only one cause mmediate Cause (Final disease or condition esulting in death)	nat caused the dea on each line.	ith. Do not ent	er the mode of dyin	g, such as cardiac or elent	respiratory arrest,		Approximate Interval Between Onset and Death
executed and and ial-transit	EXAII	ause. Enter Underlying Cause (Disease or injury hat initiated events	a to (or as a conse	and	age	ula dis	lors		86 gr
68760, ifficate be ex g physician as the burial	edical	d.							
Records, P.O. Box 61 The law requires that the death certific tee has been signed by the attending p page 2 should be detached for use as		in the past 12 months?	, outcome of pregnive birth 2 ☐ Fet regnant at time of linknown	aldeath 3□	Ectopic pregnancy Other (specify)		II	23d. Date of del Month	livery Day Year
dS, P.	a by Fr	art II. Other significant conditions contributing	to death but not re	sulting in the u	nderlying cause give	en in Part I.	23e. Did tobaco		the cause of death?
Vital Records, siclan: The law requires certificate has been signirector, page 2 should be	Completed						24a. Was an autopsy performed	? prior to death?	utopsy findings available completion of cause of
of Vital F Physician: Th rhis certificate ral director, pag	9	25. Was case referred to medical examiner? Hospital:			Oth-	26. Place of Death			
F g sig		27. Manner of Death 28a. [	1 ☐ Inpatient 2 ☐ Date of Injury Month, Day Year)	28b. Time of Injury	28c. Injun Worl	4 Nursing nom	e 5 ☐ Residence 3d. Describe how in	6 □Other (Spe njury occurred	cify)
Division or Attending after death. Director: After d in by the fune	Certification;	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined 28e.	Place of Injury - At houlding, etc. (Spec	nome, farm, str ify)			3f. Location (Street City or Town, St		ural Route Number,
	Medical	29a. Certifier 1 Certifying Physician: T (Check only one) 2 Medical Examiner: On l							
To the within To the compl	Z	29b. Signature and title of certifier	Mita		29c. License	- 4		Date signed (Mont	/
3		30. Name and address of person who completed	cause of death (Ite	om 23a) (Type,	Print) Poplie 1	21, Wi	strin or	by MI	21157
State Registra		31. Date filed (Month, Day, Year)  NOV 0 1 2006	2. Registrar's Sign	nature	SE .				

			For State Registrar	State of Mary		partmer <i>ertificat</i>						06	34661
			Decedent's Name (First, Middle, Last)						2	. Date of Death	1	V	3. Time of Death
	Physici /Medio		Eddie Gilmore						C	Month Utober	22 2	Year 206	9:35AM
	Examir		4a. Facility Name (If not institution, give s	treet and number)			Town, or	Location of	of Death		4c. County	of Death	
			Sinai Hospital	1	more	Bo	24 1 . 4 .	nore	619	4			
	Funeral		5. Social Security Number 6. Sex	M 2FF	yrs. last birthe	Months		If Under	Min.	. Daule of Birth (Month, Day,		9. Birthpl Count	tace (State or Foreign unk
2)	Director		547-90-4040 PSUSUAL Residence of Decedent		53 Yr				S	ept 29,	1953		
0	aryland ehow		10a. State 10b. County	100	. City, Town o	r Location						10	0d. Inside City Limits
3	Mar.	tor	MD		Balt	imore							1¶ Yes 2□ No
Gilmore	ith the M or 28a-f	lre	10e. Street and Number			10f. Zip	Code			10	g. Citizen of V	Vhal Coun	try?
30	th w 238	Funeral Director	4 N. Central Avenu	e			2	1203			US	SA	
ಖ		- Pu		<ol><li>Was Decedent Ever Armed Forces?</li></ol>	in U.S.	<ol> <li>Was Dece If Yes, spe</li> </ol>	dent of His	spanic Orig	gin? (Specif n, Puerto Ric	fy Yes or No- can, etc.)		e - America k, White, e	
36	s afte	by F	1 ☐ Never Married 2X Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 📉 No If Yes, Give Year or Dates:		1 🗆 Yes	2 <b>X</b> No	Specify:			Specify	b1	ack
€ d d ve 5-0036	within 72 hours after ene." then "naturel", or ite	ed	15. Decedent's Educ		16a. D	ecedent's Usu	al Occupa	ition		unk	6b. Kind of Bu	isiness/Ind	unk unk
12	nin 72 n "ne	Completed	(Specify only highest grade	completed)	((	ive kind of wo	rk done d	luring most	t of working		ob. Italia ai oa		300,7
2-5 2121	illed within Hygiene. Other then	E	Elementary/Secondary (0-12) unk uni	College (1-4or 5+)									
ਰ		Bec	17. Father's Name (First, Middle, Last)				unk	18. Mothe	er's Name (/	First, Middle, N	laiden Sumam	Θ)	unk
્ર <b>/a</b>	should be not marked o	10 E											
Known, Maryland	2 sho and le mu	11	19a. Informant's Name/Relationship (Type	pe, Print)		-				Route Number,			
₹ ₹	and feelth m 27		Sinai Hospital	Tay				edere		ue Balt			21215
Figut k	permit. Pages 1 and 2 should by Department of Heelih and Menta Important: If Item 27 Ie marked eny Injury or other traumatic engose.		20a. Method of Disposition  1 □ Burial 2 □ Cremation 3 □ Ri 4 □ Donation 5 ☑ Other (Specify)		ob. Place of D cemetery,	sposition (Na crematory or c	ne of ther place	9)	Dat	9 2	20c. Location -	City or To	wn, State
Partient Baltimo	permit. Departmitimporta	Ì	21. Signature of Funeral Service License Ronald S	9 11/1		22. Name ar State	Anato	omy B	oard (	655 W.	Baltin	nore	Street
a2	1		2.a. Part 1. Enter the disease, or complice should, or heart failure. List only on	cations that caused the e cause on each line.		Baltim enter the mod			21201 cardiac or r	espiratory arre	st,	T	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	DESSEMINO	ked in	imeva	saul.	av	was	ulohio	N		Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a cor		11.0	dia		0				
	Examine:	<u>.</u>	Sequentially list conditions.	Due to (or as a cor	race	liver	Q13	ease					
	ped list	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	1101 1-1									
	be executed icien and burial-transit	xar	that initiated events c. resulting in death) Last	Due to (pr as a con									
8760,	cate be executed obysicien and the burial-transit	dical E		4									
.89	ificate g phy as the	edic											
Вох	eath certificate be e. attanding physicien for use as the buria	M/u	230. Was decedent pregnant	3c. If yes, outcome of pro		2∏Estania n					23d. Date	e of delive	гу
	death	sicla	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at time		3 □Ectopic p 5 □ Other (sp					Mor	nth I	Day Year
0.	that the de ned by the s	hys	9 Unknown							T			
Division of Vital Records, P.O	8 5 9	Completed by Physician/Me	Part II. Other significant conditions con	tributing to death but no	I resulting in th	e underlying o	ause give	n in Part I.				ibule to the	e cause of death?
20	w require been sig	lete								24a. Was an	24b V	Vere auton	sy findings available
æ	he law e has age 2 s	E G								autopsy	ed? d	leath?	psy findings available appletion of cause of
tal	sician: The la certificate ha irector, page 3	0	25. Was case referred to medical					26 Place	of Death (	1 ☐ Yes 2 Check only one		☐ Yes	212 No
<u> </u>	ysician: is certific director,	To B	eyaminer?	ospital: Inpatient	2 ER/Outp	itient 3 D	Othe	-		5 ☐ Resider	4	ar (Specify	)
0	ig Physical dispersal di	2	27. Manner of Death	28a. Date of Injury (Month, Day Yea			8c. Injury Work			d. Describe ho			
ō	ath. or: Af	atlo	1 Natural 5 Pending investigation	(, 22) / 32	,	М		es 2 🗆	No				
)ivis	or Atter de Directo	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - building, etc. (Sp	At home, farm pecify)	, street, factor	, office		281	Location (Str. City or Town,	eet and Numbe State)	er or Rural	Route Number,
	Hoepital 4 hours a Funerel (	2	29a. Certifier \ \ Certifying Phys	ician: To the best of my	knowledge	eath occurred	at the tim	e date an	d place, and	d due to the se	uso(s) and ma		at and
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical	(Check only 2 Medical Examin	er: On the basis of examiner stated.	mination and/	r investigation	, in my op	pinion, dea	th occurred	at the time, da	te and place, a	and due to	the cause(s)
	To the within 2 To the complet	Σ	29b. Signature and title of certifier		-		. License				d. Date signed		•
			My 12 A			4	ES.	- 00	0		)ctobe	er 2	2,2006
			30. Name and address of person who con			pe, Print)	į,				<u> </u>		7
			KATJA KISELT				H	1420	TAL	or.	BALTI	MOI	76
	Sta Registi	_	31. Date filed (Month, Day, Year)  NOV 0 1 2006	32 Registrar's S	Signature	mede							

06-08142

Please Type or Print in Black Indelible Ink

Patricia Glenn State of Maryland / Department of Health and Mental Hygiene 2006 34662 1- For State Certificate of Death Registrar Reg No Physician/ 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day October 29, 2006 Medical Examine 0646 hrs Patricia Ann Glenn 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c County of Death Franklin square hospital baltimore **Baltimore County** 5. Social Security Number If Under 1 Year If Under 24Hrs 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** Age (In vrs. last birthday) Director Months Days Mir oreian 215 50 6524 44 June 20,1962 1 M 2XF Country) Marvland Usual Residence of Decedent an. 10a State 10b County 10c. City, Town or Location 10d Inside City Limits 28a-f show Yes 2 XNo Maryland Baltimore Essex Pages I and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene anti- (filem 27) is marked other than "natural", or items 23a or 28a-f sho ro other traumatic event, the Medical Examiner must be notified at once. Director 10e. Street and Number 10f Zip Code 10g. Citizen of What Country? 924 Orems Road 21221 USA Funeral 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black Armed Forces? White, etc. 1 Never Married 2 X Married 2 X No Yes Widowed If Yes. Give Year Divorced Yes 2 X No specify White Specify: 2 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry pleted during most of working life DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 12 Secretary State of Maryland Com 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Thomas Altmeyer Catherine Eiler 19a. Informant's Name/Relationship (Type, Print 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ronald B. Glenn Jr (husband) 924 Orems Road Essex Maryland 21221 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State X Burial 2 crematory or other place) Cremation 3 Removal from State Department of Important: Holly Hill Mem Gardens Nov 2, 2006 Baltimore Co.,Md. Donation 5 Other Specify or of Funeral Service Licensee Bruzdzinski Funeral Home PA 22. Name and Address of Facility 1407 Old Eastern Avenue Essex Maryland 21221 Part I. Enter the disea se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Approximate Interval failure. List only one cause on each line Between Onset and /Medical Acute myocardial infarction Death ediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Due to acute plaque rupture and thrombosis Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of) (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last that the death certificate be executed and Physician/Medical X UNPENDED the attending physician ed for use as the burial -AMENDED #23a-b,27, perME, g862, 12/4/06 TT Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy 2 Fetal death Day Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 V Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. o 23e Did tobacco use contribute to the cause of death? ş Records, P. 1 Yes 2 No 3 Probably 4 V Unknown Completed 24a Was an 24b. Were autopsy findings available has autopsy prior to completion of cause of performed? death? certificate ✓ Yes 2 1 V Yes 25. Was case referred to medical To the Hospital or Attending Physician: 26.Place of Death (Check only one) Division of Vital å Other<sub>4</sub> Inpatient 2 V ER/Outpatient 3 this DOA 1 🗸 Yes 2 Nursing Home 5 No After 27. Manner of Death 28b. Time of Injury 28a Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury accurred Certification: 1 X Natural 5 Pending after death. Funeral Director: stely filled in by the 1 Yes 2 No 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City Could not be Suicide or Town, State) determined Homicid 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started Medical (Check only To the 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifie 29c. License numbe 29d Date signed (Month, Day, Year) O.C.M.E October 29, 2006 30. Name and address of person who completed cause of death (Item 23a) Zabiullah Ali, M.D. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year, State

DHMH 17 Rev 1/2001 OCMF 2006

Registrar

ORIGINAL

		-	For L_ State	State of Maryland / Dep	artment of Health and entificate of Death	Mental Hygien	2000	34663
			Registrar		Tillicate of Death	Reg. N	lo.	3. Time of Death
	Physicia /Medic	an al	1. Decedent's Name (First, Middle, La  SHEILA DEAN  4a. Facility Name (If not institution, give	NA SIMPSON F	HENRY  4b, City, Town, or Location of Deat	OCF 28	2006	4:31 M
	Examin	<u>.</u>	5. Social Security Number 6.5	d of Boltmare	Balthouse (	147	NIA	ace (State or Foreign
	Funeral Director			□M 2 <b>5</b> SF 49 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, Yea	7957 MA	RYLAND
Maryland	ind at	tor	10a. State 10b. County  MARV/ANN	10c. City, Town or L	BALTIMO	ORE CIT	-V	d. Inside City Limits 1    Yes 2 □ No
h with the	23a or 28a at be not	ai Director	10e. Street and Number  3 700 GREEN	SPRING AVE. \$01	10f. Zip Code 2/2/	5 10g. C	tizen of What Count	ry?
ind 21215-0036 be filled within 72 hours after death with the Maryland	al', or items 23a or 28a-f ehow Examiner must be notified at	F	11. Marital Status  1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 No If Yes, Give	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer 1 ☐ Yes 2 ☑ No Specify:	Specify Yes or No- to Rican, etc.)	14. Race - America Black, White, e	tc.
Maryland 21215-0036		leted by	3 ☐ Widowed 4 ☐ Divorced  15. Decedent's E (Specify only highest gr.	Year or Dates:	edent's Usual Decupation e kind of work done during most of wo DO NOT use retired)	rking 16b.	Kind of Business/Ind	ACK
12121	and Mental Hygiene. ie marked other then "natu eumatic event, tre Medical	Completed	Elementary/Secondary (0-12)  17 Father's Name (First, Middle, Last	College (1-4or5+)	SMETOLOG		BEAUTY en Sumame)	SALON
aryland	Mental P Larked of Latic eve	To Be	WILLIE J	AMES SIMPSO	N ELLA	7 MA	E GA,	NES
, Mar	n 27 te m n 27 te m er treum		19a. Informant's Name/Relationship ( KEYSHA REID-WE	BB (DAUGHTER) 113	ing Address (Street and Number or Ri	EY WAY ED	GELLOOD, MI	0.21040
Baltimore,	Depertment of Heelth and Men Importent: If Item 27 is marks any injury or other treumatic once.		20a. Method of Disposition  1. Burial 2 □ Cremation 3 □  4 □ Donation 5 □ Other (Speci	Hemoval from State	osition (Name of ematory or other place)  EMORIAL PARK 11-0	Date 20c.	Location - City or Tov	VIII, State
Balti	Depertrumporte any injuite page.		21. Signature of Funeral Service Lice	N-Williams	2. Name and Address of Facility 3	AVE. BAL	FUNERAL 10, MP.	21217
///	ysician Medical		23a. Part1. Enter the disease, or com- shock, or heart lailure. List only Immediate Cause (Final disease or condition resulting in death)	plications that caused the death. Do not er one cause on each line.  a. Seps S  Due to (or as a consequence of):	~		7.	Approximate Interval Between Onset and Death
	aminer	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a consequence of):	/1 1etaboli(	Acides	N	
3760,	nysicien and he burial-transil	Cai	that initiated events resulting in death) Last	Due to (or as a consequence of):	,			
Vision of Vital Records, P.O. Box 68 Attending Physician: The law requires that the death certifical	by the attending phys tached for use as the	Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Onknown		□Ectopic pregnancy □ Other (specify)		23d. Date of deliver Month	y Day Year
Division of Vital Records, P.O.	gned be de	d by Ph	Part II. Other significant conditions	contributing to death but not resulting in the			use contribute to the	
Secor Blaw req	has been si ge 2 should	mpiete	MIHER Valve	Replacement		24a. Was an autopsy performed?	prior to com	sy findings available ipletion of cause ol
<u>a</u> =	certificate rector, pag		MIV			1  Yes 2	√o 1 □ Yes 2	2 🗆 No
Vit	certif	Be	25. Was case relerred to medical examiner?	Hospital:	05	ath (Check only one)	- TO:: 10	
Phys Of	this all di	<u>۲</u>	1 Yes 2 No 27. Manner of Death	1 Inpatient 2 EH/Outpatie	SIL OLI DOA TUTANSING	fome 5 ☐ Residence		
E ding	After fune	ion	1 ☑Natural 5 ☐ Pending	(Month, Day Year) Injury	ol 28c. Injury at Work? M 1 ☐ Yes 2 ☐ No		•	
DIVISION ATTEN	within 24 hours effer death. To the Funeral Director: Affer this certificate ha completely filled in by the funeral director, page	Certification:	2 Accident Investigation 3 Suicide 6 Could not to determined	De Blace of lawn. At home form of	treet, lactory, office	28l. Location (Street City or Town, Sta	and Number or Rural ite)	Route Number,
Div	in 24 hou he Funer pletely fill	Medical	(Check only 2 Medical Exa	nysician: To the best of my knowledge, dea miner: On the basis of examination and/or i and manner stated.	nvestigation, in my opinion, death occ	urred at the time, date a	nd place, and due to	the cause(s)
Tota	To t	Σ	29b. Signature and title of certifier		29c. License number	29d. [	Date signed (Month, D	
	/		9 #/		KF? -00(	) ()C	HOO 2.	8 5006
	9		Hamed Mi	completed cause of death (Item 23a) (Type	3 mai Hespliz	u of Bal	Homole	
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signature	lack o			

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Pathent Knew on Shella

State of Maryland / Department of Health and Mental Hygien 0 6 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** Harris Sr. Ernest 27 2001 retober /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Year If Under 24 Hrs. 8. Date of Birth Days Hours Min. (Month, Day, Year) 07 15 26 5+, Agnes Hospital 6. Sex 12 M 2 ☐ F 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Davs 80 NC Director 241-30-4613 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show r than "natural", or itema 23a or 28a-f sho Director 1 Yes 2 No MD NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21229 10 South Bernice Ave U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Bace - American Indian Black, White, etc. hours after 1 Never Married 2 Marned Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: Black 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 12th grade College (1-4or 5+) Armco Steel Co. 2 should be filed w and Mental Hygier is marked other th Laborer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) William Harris Martha Harris 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Heelth and Important: If Item 27 is n any injury or other traum Bertha Harris-Wife 10 South Bernice Ave, Balto, Md altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State X ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11/6/06 Garrison Forest Owings Mills, Md 21. Signiture of Funeral Service Ligensee 22. Name and Address of Facility March F/H West frome Magamores 4300 Wabash Ave, Baltimore, Md 21215 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Vasular Disease Arterioscleristic Due to (or as a consequence of): disease or condition resulting in death) In Known /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner certificate be executed the burial-transit and Due to (or as a consequence of): 68760. cete has been signed by the attending physicien page 2 should be detached for use as the burial Physician/Medical Box ( IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Month Year 4 Pregnant at time of death 5 ☐ Other (specify) P.O. 1 ☐ Yes 2 ☐ No. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ✓ No 24a. Was an this certificete has autopsy performed) 1□ Yes 2 No director, Be 25. Was case referred to medical 26. Place of Death Check only one examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No ဥ 3 ER/Outpatient 3 DOA 1 Inpatient within 24 hours after death.
To the Funeral Director: After this completely filled in burners. 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? Certification; Division 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No **Accident** Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature angitule of certifier 29c. License number 29d. Date signed (Month, Day, Year) 100853849 October 26, 2006 nd address of person who co or eted cause of death (Item 23a) (Type, Print) Agnes 900 Caton Avenue Baltimere Marylant Homital Gergern 39 Registrar's Signature 31. Date filed (Month, Day, Year) State NOV 0 1 2006 Registrar

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Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

Jessie James Ha		1- For State	ate of Maryl		artment of		Mental H		Rog No. O O	06 01661
Physicia Medical Examir	ın/	Registrar  1. Decedent's Name (First, Middl		ie Jame:	s Harris			2. Date of Dea Month October 2		3. Time-of Death D
		4a. Facility Name (if not institution 306 Anchor Lane	n, give street and n	iumber)	1	b. City, Town, or L Chester	∟oċation of Dea		4c. County of Queen A	
Funeral Director		5 Social Security Number <b>433 443</b> - 51 <b>-</b> 9825	6. Sex	7. Age (In yrs. 23	last birthday) Yrs.	If Under 1, Year Months Days	If Under 24H Hours Mi	n	rth(MM/DD/YYYY)	Birthplace (State or Foreign Country)  MS
nd thow any ce.	_	Usual Residence of Decedent  10a. State 10b County	1+imoreo		y, Town or Locati	on				10d Inside City Limits 1 Yes 2 X No
rih the Maryland 23a or 28a-f show notified at once.	Director	MD Ba 10e. Street and Number 8214 Kavanagh	ltimore			10f. Zip Code 2122	2	Dunda	aik 10g. Citizen of Wha United S	
Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral	11. Marital Status 1 XX Never Married 2 Marrie	arried 12. Was De Armed F 1 Yes orced If Yes, Give Ye	2 x No	If Ye	s Decedent of Hisp es, specify Cuban, Yes 2 X No	panic Origin? ( § Mexican, Puerl		o- 14 Race - White,	American Indian, Black,
036 dihin 72 hours a ane r than "natura dedical Examin	ompleted by	15 Decedent's Education (Spe Elementary/Secondary (0-12) 11 Years	College (	ade completed) (1-4 or 5+)		e's Usual Occupationst of working life			16b Kind of Bus Renova Home Im	,
21215-0 uld be filed w Mental Hygie marked othe	To Be Co	17. Father's Name (First, Middle,  James Earl F  19a. Informant's Name/Relations	larris		19b. Mailing		Debor	ah Campl	Maiden Surname) bell mber, City or Town,	State Zin Code)
MD and 2 show that and m 27 is aumatic	-	Brian Wright	(Friend)		306 A	nchor La	ne Che	ster, Ma	aryland	21619
more, Pages I ar ent of Hee int: If ite		20a. Method of Disposition  1 xBurial 2 Cremation  4 Donation 5 Other Sp		from State	crematory or oth	tion (Name of cem er place)		Date /3/2006		city or Town, State
Baltin permit Departm Importa		21. Signature of Funeral Service			22. N L <b>u</b> d	ame and Address	of Facility uneral	Home of	Dundalk,	
Physician /Medical Examiner	1	28a Part I. Enter the disease, or failure. List only one cause Immediate Cause (Final disease or condition resulting in death)	on each line. a. <mark>Asphyxia l</mark>	oy hanging	h. Do not enter th			or respiratory arr	rest, shock, or hear	
<b>√</b> .	, i	Sequentially list conditions, if any, leading to immediate	b	a consequence						
uted id	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as	a consequence	of):					
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cox 6876 eath certificat eattending phy for use as the	Σ!	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unit	e 23c. If yes,	outcome of pregoting the properties of design of the properties of	gnancy 2 Fet	al death 3 er (Specify)	Ectopic pregr		23d. Date of di Month	elivery Day Year
ords, P.O. Be we requires that the d s been signed by the should be detached	þ	Part II. Other significant condit	ons contributing	to death but not	resulting in the ur	nderlying cause giv	ven in Part I			ute to the cause of death?  Probably 4 Unknown
Division of Vital Records, P.O tal or Attending Physician: The law requires that te safter death al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detacted in by the funeral director, page 2 should be detacted.	Completed								pri rmed? de	ere autopsy findings available or to completion of cause of ath?  Yes 2 No
Vital   ysician: his certifi director,	o Be	25 Was case referred to medical examiner?  1 ✓ Yes 2 No	Hospital:	Inpatient 2	ER/Outpatient		of Death (Check Other 4 Nursi		Residence 6	Other Scene
ion of Vi tending Physi eath or; After this	$\vdash$	27. Manner of Death  1 Natural 5 Pend	"'y	e of Injury h Day Year) 2006	28b. Time of In		at Work?	28d. Describe Subject han	how injury occurred	1
Division E Hospital or Attendi 24 hours after death F Funeral Director.	Certification:	3 ✓ Suicide 6 Could 4 Homicide	not be	ce of Injury - At r	nome, farm, stree	t, factory, office bu	ilding, etc.	or Town, S		or Rural Route Number, City
To the Hos within 24 h To the Fur completely	Medical	29a Certifier (Check only one)  2 Medical Example 1		of examination a		on, in my opinion,	death occurred		se(s) and manner a and place, and due	
	Σ	29b. Signature and title of certifie	24	10	\	29c. License			29d Date signed October 29,	(Month, Day, Year) 2006
		30. Name and address of person Zabiullah Ali, M.D.	Assistant Medi	cal Examine	r 111 Penr	n Street, Baltin	nore, MD 2	1201		
Sta Registi		31 Date filed (Month, Day, Year)  NOV 0 1 2	006 329R	egistrar's Signat	ure	8-8				

State of Maryland / Department of Health and Mental Hygiene U U 5 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year John Albert Hockman 27, 2006 9:35 A /Medical October 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 2802 McComas Avenue Dundalk

If Under 1 Year | If Under 24 Hrs. Baltimore Co. 5. Social Security Number **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1√2 M 2□ F Days Hours 84 Director 214-18-0603 Yrs Ohio July 4,1922 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic avent, the Medical Examinar must be notified at Dundalk Director Maryland Baltimore 1 ☐ Yes 2 ☑ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2802 McComas Avenue Iteme 23a United States 21222 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1∑Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ŏ 1 ☐ Yes 2√ No δ Specify: 3

Widowed 4 □ Divorced "natural", White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. Esskay Meats Meat Packer Years other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be h and Mental h Mary Louise Dennis 2 Albert Hockman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If Item 27 is any injury or other tra (Daughter) 2800 McComas Avenue Ruth Maier Dundalk, Maryland 21222 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 4 Donation 5 Dother (Specify) Meadowridge Mem. Park 10/30/2006 Dorsey, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland art1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heer failure. List only one cause on each line. Approximate Immediate Cause (Final **Physician** disease or condition resulting in death) as Con /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury (or as a consequence of) Examine The law requires that the death certificate be executed attending physicien and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Month Year 4☐Pregnant at time of death 5 Other (specify) signed by the a ld be detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. Completed by should b 1 Yes 2 No 3 Probably 4 □Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate has t irector, page 2 s Division of Vital Hospital or Attending Physician: After this certification, funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death Check only one Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 No 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Natural 5 Pending investigation within 24 hours after death. To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 ☐ Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical To tha 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

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State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Rrint

2006

31. Date filed (Month, Day, Year)

NOV

2001

32. Registrar's Signature

		State of Maryland / Department of He State and State of Department of De	ealth and Mental Hygiene leath Reg. No. 2	6 34667
Physicia /Medic	al	Decedent's Name (First, Middle, Last)     Paul Joseph Hopkins      4a. Facility Name (If not institution, give street and number)      4b. City, Town, or L	October 29 20	Year 3. Time of Death 2006 2 A M
Examin Funeral Director	er	JOHNS HORLINS BAIVIEW MEDICAL CENTER BAL	TIMOLE	9. Birthplace (State or Foreign Country) MD
death with the Maryland ms 23a or 28a-f ahow rinnet be notified at	Director	10a. State NB County 10c. City, Town or Location Baltimore City		10d. Inside City Limits 12☐Ves 2☐No
eath with the 23a or 2	eral Dire		10g. Citizen of Wi 21224 USA	
ē <b>2</b> 9	by Funeral	1 Never Married 2 Married 1 □ Yes 2 No		- American Indian, White, etc. White
1215- within 72 ane. then "nat	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  16a. Decedent's Usual Occupati (Give kind of work done du life. DO NOT use retired)  Traffic Worke	ring most of working	
riand 2	To Be Co		8. Mother's Name (First, Middle, Maiden Sumame, Mary Elizabeth Slom	
ice, Marylan s 1 and 2 should be f Health and Mental litem 27 is marked other traumatic av		Warren Williams/nephew 5417 Hamilto	d Number or Aural Route Number, City or Town, Si on Ave Baltimore MD	tate, Zip Code) 21206
Page Page nent o ant: if ury or		20a. Method of Disposition  1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State  4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service Licensee	tory 11/1/06 Belt	ity or Town, State SVille, MD
Christian Permit Departition of Departition importation of Departition of Departi			Pastures Dr. Balti	More MD 212  Approximate Interval Between Onset and Death
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The law requires that the death certificate be evalue has been signed by the attending physicien page 2 should be detached for use as the burian	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes   2   No   9   Unknown   Unknown   Unknown   23c. If yes, outcome of pregnancy   1   Live birth   2   Fetal death   3   Ectopic pregnancy   5   Other (specify)   1   Unknown   5   Other (specify)   1   The past 12 months   1   The past 13 months   1   The past 14 months   1	23d. Date of Month	•
equires that	۵	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given		ute to the cause of death?  Probably 4 Unknown
25 8 8	Completed		performed? dea	ore autopsy findings available or to completion of cause of ath?  Yes 2□ No
s certificacto	To Be	Hospital:	6. Place of Death Check only one	
	Certification: T	27. Manner of Death 1 Natural 5 Pending investigation 2 Accident investigation 5 Could not be	s 2 No	
pitel or At purs after o erai Direc filled in by		4 Homicide determined 266. Place of injury - At nome, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number City or Town, State)	
To the Hos within 24 ho To the Fun completely	Medical	(Clisar only one)  2   Medical Examiner: On the basis of examination and/or investigation, in my opini and manner stated.	on, death occurred at the time, date and place, and umber 29d. Date signed (I	due to the cause(s)  Month, Day, Year)
3		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	35761 10/30 s Bayver Med CA / B.	106
State	<u>-</u> ا	Michael Fingelioc & MD Johns Life pkin 31. Date filed (Month, Day, Year) 32. Registrar's Signature	s Day ver red Cor B.	17 MV (1224

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HOPISINS

PAUL

			1- State of Maryland / Department of Health Certificate of Dear			iene 	16	34668
	Physici	an	1. Decedent's Name (First, Middle, Last)	2.	Date of Deat		Year	3. Time of Death
	/Medio		ELSIX HUTCHISON		ctober	27, 20	006	3:30 P M
	Examir	er		ion of Death		4c. County		
	Funeral			ider 24 Hrs. 8.	Date of Birth	Balt:	9. Birtho	place (State or Foreign
L	Director		215-28-9543 1 M 2X F 73 Yrs. Months Days Hour		(Month, Day,	1933	Coul	yland
	and W		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location					10d. Inside City Limits
	Maryli f sho	ō						1 ☐ Yes 2127 No
	r 28a	Director	10e. Street and Number 10f. Zip Code		10	Og. Citizen of \	What Cour	ntry?
	23a c	aiD	9325 Oak White Road 21236			USA		
	r dea	Funerai	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispanic If Yes, specify Cuban, Mexi	Origin? (Specify	Yes or No-		e - Americ	can Indian,
36	rs afte	<b>by</b> Fi			,	Specify	/:	
00-	72 hours after death with the Maryland natural', or Items 23a or 28a-f show deal Exercities					16b. Kind of B		lite dustry
215	within 7 ene. than "n	Completed	(Specify only highest grade completed) (Give kind of work done during material in the DO NOT use retired)  Elementary/Secondary (0-12)  College (1-4or 5+)	most of working				,
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Maryland 21215-0036	t be find Hed other	Be		other's Name (Fi			•	
Ž	2 should be and Mental is marked (raumatic ev	J.	Ira Gilbert Zepp, Sr.  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Nur	ellie K				Cadal
	ges 1 and 2 should be filed within 72 hours after death with the Marylar it of Health and Mental Hygiene. If item 27 is marked other than "natural", or Items 23a or 28a-f show or other traumatic event, If a Modical Exerting the restlined at		Kathy Kraemer / Daughter 2913 Harford Roa					
ore,	es 1 a of Hea fitem r othe		20a. Method of Disposition 20b. Place of Disposition (Name of	Date		20c. Location -		
Baltimore,	Pages ment of I ant: If its ury or o		'4 Denation 5 Hother (Special)  Bel Air Memorial Gar	dens 10	-31-06	Beil A	r. M	brelevie
Ball	permit. Pag Department Important: I any injury o		21. Signiture of Funeril Service Cicarsee 22. Name and Address of Fa McComas Funer	al Home	, P.A.			2
	40143		234 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such	y Road,	Abing	don, Ma	ıryla	nd 21009 Approximate
H	On the state of		I snock, or neart failure. List only one cause on each line.	ras cardiac or re	spiratory arre	rst,		Interval Between Onset and Death
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_	and Altrans	Examiner	that intilated events resulting in death) Last C. Due to (or as a consequence of):					
8760,	icate be executed physician and streets the burial-transit							
687	ufficate g phy: as the	Physician/Medical	a					
Вох	th cert endin r use	an/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy			23d. Dat	e of delive	ery
о. В	res that the death certification of the strending postering to be detached for use as	sicie	in the past 12 months?  1  Yes 2 No 4 Pregnant at time of death 5 Other (specify)			Moi	ith	Day Year
P.	hat th ad by detach			net l	23a Did tob	2000 USQ cont	ibuta ta t	ne cause of death?
Vital Records,	The law requires that the death certificate be executed tie has been signed by the attending physician and age 2 should be detached for use as the burial-transit	ted by	( = 0 )	att 1.	1 Yes			ably 4 Unknown
3ec	has by	Completed			24a. Was an autopsy	, p	rior to cor	psy findings available mpletion of cause of
a	ician: Th certificate rector, pag	e Co	OF the same referred to the district		_	No 1	leath?	2 No
₹	ysicia s cert	O B	examiner?	Nursing Home			e (Canaih	al mrev
0	ng Phys ter this neral di	n: T	27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day Year) 28b. Time of Injury at Work?			w injury occurr		//
sioi	ttendir death. stor: Af	atic	1 Natural 5 Pending (Month, Day Year) Injury Work? 2 Accident investigation M 1 Yes 2	No				
Division of	l or Att after d Direct I in by	Certification;	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. I	Location (Stre City or Town,	eet and Numbe State)	or Rura	l Route Number,
ч	To the Hospital or Attending Physician: The la within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2			and place and	dua to the ee	una(a) and ma		
	e Hospita 124 hours te Funeral letely fillec	Medicai	(Check only one)  2 Medical Examiner: On the basis of examination and/or investigation, in.my opinion, d and manner stated.	death occurred at	t the time, dat	te and place, a	nd due to	the cause(s)
	To the Vithin 2 To the Complet	Me	29b. Signature and title of certifier 29c. License number		29	d. Date signed	(Month, I	Day, Year)
	4		Ifm Parshall DAOOC	08	l	0 30	106	,
	10		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jim Parsh 9501 FRANKLIN SQUARE DR RALTIMOR	hale			,	
	Sta	te	31. Date filed (Month, Day, Year)  32. Registrar's Signature	E, ND	1 +	123/		
	Registr		30. Namy and address of person with completed cause of death (flem 23a) (Type, Print) Jim Parsh 9 501 FRANKLIN SQUARE DR. BALTIMOR 31. Date filled (Month, Day, Year) 12. Registrar's Signature NOV 0 1 2006					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			For State Registrer	State of Ma	ryland	Departme Certifica			mentai Hy	/giene Reg. No	0000	34669		
	Physicia		1. Decedent's Name (First, Middle, La	st)					2. Date of D Month	eath Da	y Year	3. Time of Death		
	/Medica	al .	Richard Lee	Hower					10	20	1 06	3:56PM		
	Examine	er	4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death  4c. County of Death											
			5. Social Security Number 6.5	DQUARE !	105	p Hal ist birthday) If Uni	der 1 Year	If Under 24 Hrs	B. Date of B	inth		MORE		
	Funeral Director		159-48-2456	1 <b>X</b> 1M 2□F	50	Yrs. Month		Hours Min.	8. Date of B (Month, D 9/30/	ay, Year, 1956	Penr	nplace (State or Foreign untry) nsylvania		
	and	1	Usual Residence of Decedent  10a. State 10b. County		10c. City,	Town or Location						10d. Inside City Limits		
	f ehc	٥	Marris and Delltime		77							1 ☐ Yes 2 X No		
	28a	Director	Maryland Baltimo	ore	Ess		Zip Code			10g. Ci	tizen of What Co	untry?		
9	deeth with the Maryland ms 23a or 28a-f ehow r mast ke rodffled at		812 Brunswick Ro	ad Apt 12	Δ		21221			U.	S. A.			
3	deet	ner	11. Marital Status	12. Was Decedent E				ispanic Origin? (S n, Mexican, Puer	pecify Yes or N		14. Race - Amer			
وکے	or Ite	Fu	1 Never Married 2 Married	1 Yes 27 No	0		2 <b>□X</b> No	Specify:	o riioari, etc.)		Black, White	a, etc.		
-0036	hours after turel', or Ita	Completed by Funeral	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:							Wł	nite		
( 12)	nat	lete	15. Decedent's E (Specify only highest gr	ducation ade completed)		16a. Decedent's U (Give kind of	sual Occupa work done o Luse retired	ation during most of wo i)	rking	16b. k	(ind of Business/I	ndustry		
12	within 72 ene. than "ne.	mc.	Elementary/Secondary (0-12)	College (1-4or 5+	' I	Carpenter		,		Co	nstructi	ion		
N D	il Hygie other	Be C	17. Father's Name (First, Middle, Last	)	L.	Carpencer		18. Mother's Nar	ne (First, Middle			LOII		
Maryland	200	10 B	Edward Hower					Alfreda		avit				
Mar	2 sh and is m	7	19a. Informant's Name/Relationship			19b. Mailing Addre								
	1 and 16elth 10m 27 ther t		John Hower (Bro	other)	20h Pla	696 Char	el Dr	rive Ler	nighton,		insylvani ocation - City or 1			
و	80=5		1 □ Burial 2 🛣 Cremation 3 🛭			ace of Disposition (/ metery, crematory of								
Baltimore,	# E E E		4 □ Donation 5 □ Other (Speci		Bayv	view Crema			0/2006	_		Maryland		
Ba	Depe Impo		1766			Bruzo 1407	dzinsk Old E	i Funera astern A	l Home	PA Esse	x. Marv]	land 21221		
			23a. Part1. Inter the disease, or comshock, or heart failure. List only	plications that caused to	he death.	Do not enter the m	ode of dying	g, such as cardia	or respiratory	arrest,		Interval Between		
7	Physician		Immediate Cause (Final disease or condition resulting in death)	· acute	P	Neumo	nia					Onset and Death		
	/Medical Examiner		resulting in geath)	Due to (or as a	conseque	ence of):				1				
		<u>ت</u>	Sequentially list conditions, if any leading to immediate	b. adult Due to (or as a	conseque	DIRATOR	4 9	115+Ress	SYN	deor	ne			
V	uted	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events			,								
oʻ	be executed icien and burial-transit	Exa	resulting in death) Last	Due to (or as a	conseque	ence of):								
09289	the the	edical	•	d										
	E Ones		IF FEMALE:	23c. If yes, outcome of	f pregnan	NOV.								
Вох	atten for u	clan	23b. Was decedent pregnant in the past 12 months?	1□Live birth 2	Fetal	death 3 ☐ Ectopic					23d. Date of deli- Month	very Day Year		
	thet the death cert ed by the attendin detached for use	hysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown			(-,,,,							
ω̂. OT	The law requires that the death cersite has been signed by the attendingage 2 should be detached for use	by Physician/M	Part II. Other significant conditions		not resul	lting in the underlyin	g cause give	en in Part I.	23e. Did	tobacco	use contribute to	the cause of death?		
ğ	w require been signature	ted	hiver c	irrhosis					1 🗆	Yes 2	No 3□Pro	obably 4 Unknown		
ec	hes be	Completed							24a. Was	psy	24b. Were aut	opsy findings available ompletion of cause of		
=									pert 1 ☐ Yes	ormed? 2 2 No	death?	2 No		
V Its	sicien: The certificete irector, pag	Be	25. Was case referred to medical examiner?	Hospital:			DOA Othe	26. Place of Dea						
o to	Phys r this ral dir	2	1 ☐ Yes 2 ☑ No 27. Manner of Death	1 X Inpatien		R/Outpatient 3 28b. Time of	DOA	4 🗀 Nursing F	fome 5 ☐ Res 28d. Describe		6 ☐Other (Spec	ify)		
o	Attending Physicien: r death. ector: After this certific by the funeral director,	i i	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day	Year)	Injury M	28c. Injury Work	(? Yes 2 ∐No			.,			
Division of Vital Records, P.O	er dea rector by the	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injur	y - At hon (Specify)	ne, farm, street, fact	ory, office		28f Location City or To	(Street ar	nd Number or Rus	ral Route Number.		
۵	Hospital or 24 hours efte Funeral Dir tely filled in 8		29a. Certifier 1☑ Certifying Pl	4.			and on the con-	o data and it.						
	To the Hospital or Attending Physwithin 24 hours effer death. To the Funeral Director: After this completely filled in by the funeral directors.	Medical	(Check only one)	<b>nysicien:</b> To the best of miner: On the basis of a and manner state	xamınatio	on and/or investigati	ed at the tim on, in my op	ne, date and place pinion, death occu	r, and due to the urred at the time	cause(s , date an	) and manner as d place, and due	stated. to the cause(s)		
	vithir To th	ž	29b. Signature and title of certifier				29c. License			29d. Da	te signed (Month	, Day, Year)		
			1	_			D37	612		)	0/29/0	lo		
	$\cap$		30. Name and address of person who		_						1			
			DR. Mohamad ( 31. Date filed (Month, Day, Year)	Va brash	90	00 Fran	Klin S	sq.de.	Baltin	ORE	, MD c	21237		
	Stat Registra		NOV 0 1 2006	32. Registra	s signati	hopete?								

DHMH 17 Rev 1/2001

		1 - For State Registrar	State of M	aryland / Dep <i>Ce</i>	artment of He rtificate of D	ealth and N	∕lental Hygi	ene Legib	6 34670
Phys /Me	ician dical	1. Decedent's Name (First, Middle Elizabeth Jane	Hoosier				2. Date of Death Month October	Day Y	3. Time of Death 6:15 A M
Exan	- ta	4a. Facility Name (If not institution  Laurelwood Cent  5. Social Security Number	er	B //p.urs last high days	4b. City, Town, or L  Elkton  If Under 1 Year	ocation of Death		4c. County of Cecil	Death
Funer Directo		212-26-9720 Usual Residence of Decedent	1 DM 12 DF	e (In yrs. last birthday, Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, Aug. 9,		n. Birthplace (State or Foreign Country) [aryland]
e Marylan Be-f ehow	ctor	Maryland Ceci	1	10c. City, Town or Li Port Dep					10d. Inside City Limits 1 ☐ Yes 2 ☑ No
Ind 21215-0036  be filed within 72 hours after death with the Maryland ital hygiene. Indicate then "natural", or items 23a or 28e-f show event, the Medical Examinar must be notified at	by Funeral Director	10e. Street and Number  1803 Belvidere  11. Marital Status  1 Never Married 2 Marri 3 Widowed 4 Divorced	12. Was Decedent Armed Forces?	No	10f. Zip Code  21904  Was Decedent of Hisp If Yes, specify Cuban,  1 □ Yes 2★ No		Black, Specify:	at Country?  American Indian, White, etc.  White	
21215-0036 ad within 72 hours aff gjene. er than "natural", or the Medical Exem.	Completed	15. Decedent (Specify only highes Elementary/Secondary (0-12)	s Education grade completed)  College (1-4or 5	i+) (Give	dent's Usual Occupati kind of work done du DO NOT use retired)	on ring most of work	ing	6b. Kind of Busin	
yland 2 ould be filed v Mental Hygie arked others	To Be Co	17. Father's Name (First, Middle, L Marcus Charles		Home Home			e (First, Middle, M	,	
Mar nd 2 shr alth and 27 is m		19a. Informant's Name/Relationsh Richard Hoosier	ip (Type, Print)		ng Address (Street and	d Number or Run		City or Town, Sta	ate, Zip Code)
Baltimore, I  Dermit. Pages 1 and Department of Healt mportent: if item 2		20a. Method of Disposition 1 ☐ Surial 2 ☐ Cremation 1 ☐ Other (Sp	Removal from State	20b. Place of Dispo cemetery, crei		11 (	Date 20	Oc. Location - Cit	y or Town, State
Baltimo permit. Pag Department Importent: I any injury o		MAMAN	ensee	1 N	Name and Address IcComas Fur 317 Cokesh	of Facility neral Hor	me, P. A.	n Marsz	Maryland land 21009
Pnysicial		23a Part Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition	T.	the death. Do not entire.	er the mode of dying,	such as cardiac (	or respiratory arres	t,	Approximate Interval Between Onset and Death
/Medica Examine		resulting in death)  Sequentially list conditions,	b	a consequence of):					
icate be executed physicien and the burial-transit	cal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
OI VILAI RECORDS, P.O. BOX 68 Physicien: The law requires that the death certifica this certificate has been signed by the attending ph ral director, page 2 should be detached for use as th	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1							delivery Day Year
COTGS, P	b	Part II. Other significant condition		it not resulting in the ui	nderlying cause given	in Part I.	m		te to the cause of death?  Probably 4 Unknown
al KECOLOS,  The law requires t cate has been signe page 2 should be of	Completed						24a. Was an autopsy performe	d? prior	e autopsy findings available to completion of cause of h? Yes 2 \( \subseteq \) No
DIVISION OT VITAL MEGINAL IN OR VITAL THE LANGUAGE AND THE LANGUAGE AND THE CONTRICATE HAS THE THE CONTRICATE HAS THE THE THE LANGUAGE AND THE THE LANGUAGE AND THE THE LANGUAGE AND THE THE CONTRIBUTE AND THE THE LANGUAGE AND THE THE LANGUAGE AND THE THE LANGUAGE AND THE THE LANGUAGE AND THE THE LANGUAGE AND THE THE LANGUAGE AND THE THE LANGUAGE AND THE LANGUAGE	ation; To Be	25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death Natural 5 Pending 2 Accident investiga	Hospital: 1 ☐ Inpater  28a. Date o injun (Montri, Day	28b. Time of	t 3□ DOA Other: 28c. Injury at Work?	Nursing Hor	(Check only one)  ne 5  Residence 28d. Describe how		Specify)
DIVISION  To the Hospital or Attending I within 24 hours after death.  To the Funeral Director: After completely filled in by the funer	Certification:	3 Suicide 6 Could no determin	the	ry At home, farm, stre			28f. Location (Stree City or Town, S	et a <i>nd N</i> um <i>ber o</i> State)	r Rural Route Number,
To the Hospital or within 24 hours after To the Funeral Dir completely filled in	edicai	one)	Physici in To the best of caming in the basis of and manner state	examination and/or inv	occurred at the time, estigation, in my opini	date and place, a on, death occurre	and due to the caused at the time, date	se(s) and manne and place, and	r as stated. due to the cause(s)
^	₹	29b. Signature and title of certifier	H//24		29c. License nu DS 40			Date signed (M	
1)		30. Name and address of person w  ACC   31. Date filed (Month, Day, Year)	VI 57000	- (Mo		2CHMAN!	cn	Newcas	7 LE DE 19720
S Regis	tate trar	NOV 0 1 200	32. Registra	S Signature	£ )				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TITEM#7. per FH. C861.11 / 6/06, WS

			For State Registrar		State of Ma	ifyla <del>lld</del> 7		rtment of F tificate of			iene g. No.	06	34671		
	Physicia	an	1. Decedent's Name (First, Mid	dle, Last)	Turlin To	Tono				2. Date of Death Month	Day	Year	3. Time of Death		
	/Medic Examin		4a. Facility Name (If not institut	on, give st	Julia Le	e Jone	es ,	4b. City, Town, o	r Location of Death	IVETO NOR	4c. Cour	100 C	6.10 5		
	Funeral Director		5. Social Security Number 212-77-5110	6. Sex	M 2 X F	PitA (In yrs. last)	birthday) Yrs.	If Under 1 Year Months Days 66	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Aug 23,	Year) 2006	9. Birth Cou Mary	place (State or Foreign intry) 7 Land		
	D		Usual Residence of Decedent 10a. State 10b. Coun	tv .		10c. City, To	own or Loc				10d. Inside City Limits				
	Maryla f ehor	ğ	MD Anne		de1	Jessi		ation					1 ☐ Yes 2 ☑ No		
	r 28a-	Irec	10e. Street and Number	711 011	ucz	00220	~	10f. Zip Code			Og. Citizen	of What Cou	intry?		
	ath wit	raid	2039 Citrus A					20794			J.S.A.				
0000	permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Heelih and Mental Hygiene. Department of Heelih and Mental Hygiene.  The marked other then "naturel", or items 23a or 28a-f show any injury or other traumatic event, the Moulcal Examinar must be notified at once.	by Funeral Director	11. Marital Status  1 ☑ Never Married 2 ☐ M. 3 ☐ Widowed 4 ☐ Divorc	rried	<ol> <li>Was Decedent E Armed Forces?</li> <li>1 ☐ Yes 2 X N If Yes, Give Year or Dates:</li> </ol>			/as Decedent of F Yes, specify Cub.	lispanic Origin? (Sp an, Mexican, Puerto Specify:	ecity Yes or No- Rican, etc.)	В	lace - Amer llack, White <sup>cify:</sup> Whit	, etc.		
5	72 hou	eted	15. Deced (Specify only high	ent's Educ	ation completed)	16	Sa. Deced	ent's Usual Occup	oation during most of work d)	king	16b. Kind of	Business/I	ndustry		
7	within 9ne. Ithen	Completed	Elementary/Secondary (0-12		College (1-4or 5	+>	n/a	O NOT use retire	a)		n/a				
ממ	il Hygin other	0	17. Father's Name (First, Middle	e, Last)		!	11, 4		18. Mother's Nam	e (First, Middle, M	Maiden Sum	ame)			
yiand	Menta Menta Mrked mrked	To B	Timothy Brian							Marie Ha					
Mar	12 sho h and 7 ie m traum		19a. Informant's Name/Relatio						and Number or Ru		· .				
9	Heeltl Heeltl tem 2		Melissa M. Ha 20a. Method of Disposition	nna /	mother			ition (Name of atory or other pla	zenue, Je	-	20c. Locatio				
Ē	Pages nent of int: If I		1 Burial 2 Crematio 4 Donation 5 Other		emoval from State				tery Nov	1, 06	Brentv	vood,	Maryland		
Baitimo	permit. Departm Importa any inju		21. Signature of Funeral Service	License		M00773	Do		ss of Facility Funeral t Ave. L			nd 207	707-4389		
			23a. Part1. Enter the disease, shock, or heart failure. L	or complic st only one	ations that caused e cause on each lin	the death. D	o not ente	r the mode of dyl					Approximate Interval Between Onset and Death		
)	Physician		Immediate Cause (Final disease or condition resulting in death)	_ a.	Complica	tions	DF)	4,00 plas-	tic left	head c	SYNdR	ome	2 months		
	/Medical Examiner		1050ttaig in 352th)		Due to (or as	a consequence	ce of):	Caldin	4 1025	- 11d (2)	1 (147)		Leanalle		
١,		Jer	If any, leading to immediate Due to (or as a consequence or).								CINV		4 ( p. 40)		
	and transi	Examin	Cause (Disease or injury that initiated events	Sause (Disease or injury) nat initiated events c.  substitution in death) Last  Due to (or as a consequence of):											
8/60,	ficate be executed  physicien and is the burlal-transit	alE	Due to (or as a consequence or).												
20	tificate ig phys as the	ledical		0.											
O. Box	at the death certific by the ettending priached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	to 12 months?  4 Pregnant at time of death  5 Other (specify)								23d. Date of delivery Month Day Year			
s,	E 20	by Ph	Part II. Other significant cond	itions con	tributing to death bi	ut not resultin	g in the un	derlying cause gr	ven in Part I.	23e. Did tob	acco use c	ontribute to	the cause of death?		
rds	w requires to been signed should be									1 □ Ye	s 2 PNo	3 □ Pro	bably 4 Unknown		
II Kecord	The law ete has b page 2 sl	Completed								24a. Was an autops perform	y	b. Were au prior to d death? 1  Yes	topsy findings available completion of cause of 20No		
N I I	Physicien: Th this certificete ral director, pag	Be	25. Was case referred to med examiner?		ospital:			Ott Box Ott	ner	th (Check only on		245 /2			
ō	ding Phys h. After this i funeral dir	n: To	1 ☐ Yes 2 ☐ No 27. Manner of Death		1 Dispatie 28a. Date of Inju (Month, Da)		Outpatien b. Time of	28c. Inju	4   Nulsing n	ome 5 Reside 28d. Describe ho			iry)		
oi oi	anding ath. or: Afte	atio	Z D / tooldoint	stigation	(MORIII, Da)	y rear)	Injury		Yes 2 □No						
DIVISION	al or Attending s efter death. al Director: After ed in by the fune	Certification:	3 Suicide 6 Cou	ld not be mined	28e. Place of Injubulding, etc.	ury - At home c. <i>(Specify)</i>	, farm, stre	eet, lactory, office		28f. Location (St. City or Town		mber or Ru	ral Route Number,		
	To the Hospital of within 24 hours of To the Funeral D completely filled in	Medical			ician: To the best er: On the basis of and manner sta	f examination									
	To the within 2 To the comple	Σ	29b. Signature and title of cert	fier	21 mg	,		29c. Licen	Se number 06/8/4	/3	9d. Date sig	ned (Month	n, Day, Year)		
,	2			~ /	1 1		In \ /T:		00/8/9		ctobe	3p 3	0,2004		
	2		30. Name and address of pers	Dezh	lian Lin	1/1	DOLL	= df 12	Altimore,	Maryla	nd s	2128	7		
	Sta Registi		31. Date liled (Month, Day, Ye	1 200	32. Begistr	ar's Signature	Par	W.		Ţ					

			1 - For State Registrar	State of M	Marylan	•	artmen rtificat				fental Hy	gien Reg. N	201	06	34	672
			Decedent's Name (First, Middle, La	st)							2. Date of D		214	Vaar	3. Tim	e of Death
	Physici		Adelaide				į	Jack	son		OCTOB		ay 3D 2	Year	3:	30PM
)	/Medic Examin		4a. Facility Name (If not institution, giv	e street and number	er)		4b. Cily,	Town, or	Location	of Death		4	c. County	ol Death		
			ST. ABNES HO.	SPITAL.			1.		MOR							
	Funeral		5. Social Security Number 6. S	ex 7 □M 2XF		last birthday)	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of B	ay, Yea	7) 7.0	9. Birth	olace (Stantry)	te or Foreign
	Director		212-14-0990		87	Yrs.					06	27_	19			NC
	and and		10a. State 10b. County		10c. Cit	ty, Town or Lo	cation								10d. Insid	B City Limits
	daryl f • ho	ō	MD NA		В	altimo	ore								1 🔣	res 2□No
	28a-	Director	10e. Street and Number				10f. Zip					10g. C	itizen of V		ntry?	
	3a or	ā	3612 Springdal	.e Ave				2	2121	6			U.S	. A .		
	should be filed within 72 hours after death with the Maryland ind Mental Hygiene. Inarked other than "neturel" or items 23a or 28a-f show inmatic event, the Medical Examinar nast be notified at	Funeral	11. Marital Status	12. Was Decede Armed Force		I.S. 13.	Was Deced	dent of H	ispanic Or	rigin? (Sp	ecify Yes or N Rican, etc.)	lo-		e - Ameri k, White,	can Indian	٦,
9	or its	F.	1 Never Married 2 Married	1 Yes 2			1□ Yes	•	Specify		,		Specify		lack	
90	uret',	d by	3 Widowed 4 Divorced	Year or Date	s:							101				
ν.	"net	Completed	15. Decedent's E (Specify only highest gra	ide completed)		16a. Dece	dent's Usu: kind of wo DO NOT u:	rk done d	during mo:	st of work	ing	160.	Kind of Bu		•	
2	withir ene. then	E G	12th grade	College (1-40	or 5+)				loni	st			H	losp	ital	
0	filed Hygi Sther ent,		17. Father's Name (First, Middle, Last	)					18. Moth	er's Nam	e (First, Middl	e, Maide	n <i>Sum</i> am	10)		
<u>a</u>	id be ked ked	To Be	Norman Powell						E11	a Po	owell					
Maryland 21215-0036	shou and N mar	-	19a. Informant's Name/Relationship (			19b. Mailin	ng Address	(Street	and Numb	er or Run	al Route Num Cat	ber, City	or Town,	State, Zij	Code)	21228
Σ	and 2 elth a 27 i		Joan Nunley-Dau	ighter								,				
ore	of He		20a. Method of Disposition 1 □ Meurial 2 □ Cremation 3 □	Removal from Sta		Place of Dispo cemetery, crei	sition (Name of the control of the c	ne of other plac			Date		Location -	•		
Ĕ	Pag ment ant:		4 ☐Donation 5 ☐ Other (Special	y)		Drui				11/4	1/06	Pi	kesv	7ill	e, M	ld
Baltimore,	permit. Pages 1 and 2 should be Department of Heelih and Menia Important: If item 27 is marked any injury or other traumatic ev. DDCE.		21. Signature of Funeral Service Lice	a h / do		Ma	2. Name ar rch 00 W	F/H	Wes	t	Balti	mor	e, M	1d	2121	.5
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caus	sed the deat										Approxi	mate Between
	Physician		Immediate Cause (Final disease or condition	SEP.											Onset a	nd Death
/	/Medical		resulting in death)	. d	as a conseq	quence of):										·/ <u>-</u> ·
	Examiner		Sequentially list conditions,	, STR	OKE										2001	EEKS
	P ci #	ner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or	as a consec	quence of):										
	trans	Examiner	that initiated events resulting in death) Last	C	as a conseq	ruence of):										
8760,	ficate be executed physicien and is the burial-transit	ai E		Due to (or	us u conseç	querico ory.										
	phys phys the	dicai		d												
×	Attending Physicien: The law requires that the death certific sr death.  stock all.  ector: After this certificate has been signed by the ettending p by the funeral director, page 2 should be detached for use as	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcor									23d. Dat	te of deliv	ery	
B	etter for L	ciar	in the past 12 months?	1□Live birth 4□Pregnan			⊒Ectopic p ⊒ Other (sc				_		Mo	nth .	Day	Year
o.	the cachec	hysi	9 □ Unknown	9□ Unknow	1											
'n.	res that the de signed by the e i be detached f	γP	Part II. Other significant conditions	_			nderlying o	ause giv	en in Part	l.	23e. Dio	tobacco	use conti	ribute to I		/
Ď	w require been sig should b	edt	LORONARY A	RTERY	DISE	ASE.					1	Yes	2 🗆 No	3 🗌 Pro	bably 4	☑Unknown
ပ္က	aw re is bed 2 sho	Completed									24a. We	s an opsy	24b. \	Were auto	opsy lindir	ngs available of cause of
ř	The lav	E									per 1 ☐ Yes	formed?		death?	2□ No	
<u>ta</u>	ian: rtifica ctor, I	Be	25. Was case referred to medical examiner?						26. Plac	e ol Deat	h (Check only	one)				
<u>&gt;</u>	hysic nis ce I direc	To	1 Yes 2 No	Hospital: 1 1 Inp.		ER/Outpatier			401	ursing Ho	ome 5 Re				<i>fy</i> )	
0	ng P	e E	27. Manper of Death 1. ■ Natural 5 □ Pending	28a. Date of I (Month,	njury Da <i>y</i> Yea <i>r)</i>	28b. Time o Injury		28c. Injun Wor			28d. Describe	how in	ury occurr	red		
Sio	tendi leath. tor: A the fu	cati	2 Accident investigation 3 Suicide 6 Could not to				М		Yes 2□	No	281 Legation	(Ctroot	a and Alicenta	ar ar Du	al Davita I	(h. mho s
Division of Vital Records, P.O. Box	or At	Certification:	4 Homicide determined	200. Flace of	injury - At h etc. (Special	ome, larm, sti fy)	reet, factor	y, office				ation (Street and Number or Rural Route Number, or Town, State)				vu <i>mber,</i>
_	To the Hospital or Attending Physician: The I within 24 hours elfer death.  To the Funerel Director: After this certificate ha completely filled in by the funeral director, page			nysician: To the be												
	e Ho.	Medical		miner: On the basi and manner	s of examina											se(s)
	Within To th somp	Me	29b. Signature and title of certifier	_			29	c. Licens	e number			29d. D	ate signed	d (Month,	Day, Yea	ir)
			my Prati	a 1	MD		I	00	6316	66		OC	TOBE	R 3	0 20	006
	2		30. Name and address of person who									_				
				PITAL		CATO	NA	VEN	VE	BA	LTIMO	RE	MI	> 2	228	,
	Sta	ate	31. Date filed (Month, Day, Year)	32. Reg	istrar's Signa	ature	10 a									

DHMH 17 Rev 1/2001

ADELAIDE

JACKSON,

			For State Registrar	State of Maryl			of Health and of Death	Mental H	ygiene Reg. No.	1115	34673
	Physici		1. Decedent's Name (First, Middle, Last)	Matthew I	aniel	Jachel	ski	2. Date of D		Year 20	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give s Saint Joseph		enter	4b. City, To	own, or Location of De			County of Dea	
	Funeral Director		213-06-7702	7. Age (In ) km 2□F 23	vrs. last birthday) Yrs.	If Under 1 Months	Year If Under 24 H Days Hours Mi		lay, Year)	1 6	thplace (State or Foreign country) aryland
	e Marylend 3e-f ehow	ctor	Usuat Residence of Decedent           10a. State         10b. County           Maryland         Baltir		City, Town or Lo	ocation		Dundal	.k		10d. Inside City Limits 1 ☐ Yes 2∰No
	3e or 28	I Director	10e. Street and Number 7504 Poplar Ave	anile		10f. Zip C	ode 21224			en of What Co	*
980	d within 72 hours effer death with the Maryland glefre. Then "naturel", or Iteme 23e or 28e-f ehow the Medical Exaturer must be inclibed at	by Funeral		12. Was Decedent Ever in Armed Forces?  1 ☐ Yes 2₹34\0 If Yes, Give Year or Dates:		Was Deceder If Yes, specify	nt of Hispanic Origin? Cuban, Mexican, Pu	(Specify Yes or Nerto Rican, etc.)	lo- 1	4. Race - Ame Black, Whit	encan Indian,
Baltimore, Maryland 21215-0036	l within iene. r then	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	cation o completed) College (1-4or 5+) 2 Years	(Give	dent's Usual ( kind of work DO NOT use unteer	done during most of w	vorking	Bal	d of Business	Industry County
land 2	el Hy el Hy I othe vent,	To Be C	17. Father's Name (First, Middle, Last)  Daniel A. Jache				18. Mother's N	ame (First, Middl Thelma			
, Mary	es 1 end 2 should b of Heelth and Ment of Item 27 le marked r other treumatic		19a. Informant's Name/Relationship (Ty) Mr. Daniel A. Jack				Street and Number or ar Ave. D	Rural Route Num. Dundalk,			Zip Code) 1224
more	Pages 1 on nent of He nent if item		20a. Method of Disposition 1 ⊠Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	b. Place of Dispo cemetery, crei Holly Hi	natory or othe	of er place) . Gdns. 11	Date ./2/2006		ation - City or Idle Ri	Town, State Ver, MD
Balti	permit. Pages Depertment of h important: if its eny injury or of once.	į	21. Signature of Funeral Service Livense Faul L. Har	took. De			Address of Facility Ck Funeral se Ave. I				nc. 1222
	death certificate be executed e attending physicien end nd for use as the burial-transit	dical Examiner	23a. Pan1. Enter the disease, or complications, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	e cause on each line.  GROUF B  Due to (or as a con:	STEPT sequence of):		of dying, such as cardi		arrest,		Approximate Interval Between Onset and Death 4 DAYS
P.O. Box 6	\$ £ £	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	1 Live birth 2 F	. If yes, outcome of pregnancy  1  Live birth 2  Fetal death 3  Ectopic pregnancy  4  Pregnant at time of death 5  Other (specify)						ivery Day Year
	8 6 8	þ	Part II. Other significant conditions con	tributing to death but not	resulting in the u	nderlying cau	se given in Part I.		tobacco us	/	the cause of death?
<u> </u>	The law ete has b page 2 si	Completed						24a. Wa: auto perf 1 Yes		24b. Were au prior to death? 1 \( \text{Yes}	utopsy findings available comptetion of cause of 2 No
f Vit	S S D	To Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☒ No	ospital: 1 🕅 Inpatient 2	P ☐ ER/Outpatier	at 3 DOA	Other	eath Check only Home 5 Res		Other (Spec	cify)
ion o	Attending Phrideath. ector: After they the funeral		27. Manner of Death 1 X Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year	28b. Time of Injury	28c	Injury at Work?	28d. Describe	how injury	occurred	
Divis	2 4 4 5	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - A building, etc. (Spe	t home, farm, str ecify)	eet, factory, o	ffice	28f. Location City or To	(Street and own, State)	Number or Ru	ural Route Number,
	Hospital     24 hours e     Funerei C     Istely filled i	edical	29a. Certifier (Check only one) 1  Certifying Phys 2  Medical Examin	ician: To the best of my ler: On the basis of exam and manner stated.	knowledge, death ination and/or in	occurred at vestigation, in	the time, date and pla- my opinion, death oc-	ce, and due to the curred at the time	cause(s) a date and p	and manner as place, and due	stated. to the cause(s)
	To the Vithin 2.	Me	29b. Signature and title of certifier	· wille	R.J.	29c. L	D 36663			signed (Mont)	
	Sta	te	30. Name and address of person who con  STUART R. WIL.  31. Date filed (Month, Day, Year)		7601	·	DRIVE,	TOWSON,	MAR	YLAND	21204
	Registr	ar	NOV 0 1 2006	198 0 152 B	I STEEL	Biller					

DHMH 17 Rev 1/2001

Registrar

		For State Registrar		State of Ma	aryland / [	Department of I Certificate of			giene 0	6 34675			
	ysician	Donal	Name <i>(First, Middle, La</i>	JOSEPH	F	CLINE		2. Date of De. Month	Day Y	aar 19.40 Pm			
· ·	Aedical aminer	Fran	me (If not institution, gi	uare Hos	spital	Ros	or Location of Dea	ath	4c. County of Bal	timore			
Fun Dire			8 7008	Sex 1 X M 2 ☐ F	9 fin yrs. last bii 74	thday) If Under 1 Year  Yrs. Months Days	If Under 24 Hr Hours Min		y, Year) 932	. Birthplace (State or Foreign Country) MD			
with the Marylend	fledat	10a. State	10b. County  BALTIM	ORE	10c. City, Tow	n or Location LE RIVER				10d. Inside City Limits 1 ☐ Yes 2 ☑ No			
vith the	be nutified	10e. Street and				10f. Zip Code			10g. Citizen of Wha	at Country?			
₹ 5	Examiner must	11. Marital Sta	ENECA PARK tus  Married 2  Married 2  Married 4  Divorced	12. Was Decedent I Armed Forces? 1 GYes 2 N		21220  13. Was Decedent of If Yes, specify Cut  1 □ Yes 2 No	an, Mexican, Pue	(Specify Yes or No erto Rican, etc.)	Black,	American Indian, White, etc. WHTTE			
Taryland 21215-0036 2 should be filed within 72 hours after dee and Mental Hygiene. ie marked other them "netural; or items	disal		15. Decedent's E Specify onfy highest g	Education rade completed) College (1-4or 5	16a	Decedent's Usual Occu (Give kind of work done life. DO NOT use retire ICHEN DESIGN	during most of w		16b. Kind of Busir	ness/Industry			
rland 2.	or other traumatic event, the Ma	17. Father's N	12 ame (First, Middle, Las E	0 KLINE	KI	ICHEN DESIG	T	ame (First, Middle	Maiden Sumame)  DORBERT	NSTRUCTION			
Maryla 12 should 1 and Men	rauma	19a. Informar	t's Name/Relationship		16	o. Mailing Address (Stree							
Baltimore, Misperim Pages 1 and 2 Dependent 18 to 18 of 18 o	ry or other t	LINDA  20a. Method of 1  Buria 4 Dona		KLINE/WIFT	20b. Place o	328 SENECA INTEGRATED IN THE SERVICE STATES IN THE SERVICE SER	ace)	MIDDLE Date 03–2006	20c. Location - Ci	ty or Town, State			
Balti permit P Depertmi importer	eny inju		of Fursi I Sayvice Lic	1		22. Name and Addr	ess of Facility (	VACH/ROS	EDALE FUN	JERAL HOME 21237			
S8760, Wed Exam licate be executed bhysicien end	the burial-transit	shock, of Immediate or codes are cod	in heart failure. List onli ause (Final ndition path) ist conditions, to ambediate Underlying se or injury wents	Due to (or as	g Ca	±0·	ng, such as card	ac or respiratory a	11631,	Approximate Interval Between Onset and Death			
O. Box 6. The death certification of the attending of the	thed for use as	IF FEMALE: 23b. Was dec in the pa 1  Yes 9 Unk	cedent pregnant ist 12 months? 2 \( \subseteq No		23d. Date of delivery Month Day Year								
rds, P.O. quires thet the			significant conditions		pacco use contribute to the cause of death?  as 2 No 3 Probably 4 Unknown								
al Record : The faw requ	page 2							24a. Was auto perfo 1 Yes	ormed?   dea	ere autopsy findings available or to completion of cause of ath?  Yes 2 \( \sum \) No			
on of ding Phy h.	을 타	2 1 ☐ Yes	2 No Death al 5 ☐ Pending	Hospital: 1 Inpatie 28a. Date of Inju (Month, Da		Time of 28c. Injury W	ther: 4 🗆 Nursing	Home 5 ☐ Res	eath (Check only one)  Home 5 Pesidence 6 Other (Specify)  28d. Describe how injury occurred				
Divisio	d in by the	27. Manner of 1 Natur 2 Accid 3 Suici 4 Hom	de 6 ☐ Could not	be 28e. Place of Inj	jury - At home, t c. (Specify)	arm, street, factory, office		28f. Location ( City or To	(Street and Number wn, State)	or Rural Route Number,			
DIV To the Hospital or A within 24 hours after To the Funeral Director To the Funeral Director Directo	npletely fille	29a. Certifier (Check o one)	nly 2 Medical Ex	Physician: To the best aminer: On the basis o and manner st	of examination a	ge, death occurred at the nd/or investigation, in my	opinion, death or	ice, and due to the courred at the time,	, date and place, an	d due to the cause(s)			
To T	uos	•	e an stitle of pertitier  2  address of person with	o completed cause of c	death (Item 23a	De	331	3	29d. Date signed (	MONIN, DAY, YEAR)			
R	State egistra		(Month, Day, Year)  OV 0 1 2006		rar's Signature	Klin Squ	narly	rive B	altog MC	121237			

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** KATHLEEN BERNADETTE October 2006 7:05 p M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel 3384 Old Line Avenue Laurel 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Y Oct 22 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign Year) 1935 **Funeral** Days Hours 1 □ M 2 □ K Pennsylvania **Director** 178-26-5888 71 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County "natural", or items 23a or 28a-f show idical Examiner must be notified at 1 ☐ Yes 2 📆 💢 do Director Maryland Anne Arundel Laurel 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 20724 U.S.A. 3384 Old Line Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 XXIo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race · American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married 1 ☐ Yes 2XXXVo by Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12)
Grade 12 College (1-4or 5+) Library Circulation Assistant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Michael Coyne Helene King 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3384 Old Line Avenue Laurel, Maryland 20724 Albert Kreuz spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition XBurial 2 ☐ Cremation 3 ☐ Removal from State Meadowridge Mem. Pk. 10/31/2006 4 □ Donation 5 □ Other (Specify) Dorsey, Maryland 21. Signature of Funeral Service Licensee 22 Name and Address of Facility
Donaldson Funeral Home, P.A. M00770 313 Talbott Avenue Laurel, Maryland 20707 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Cerebrovascular Accident disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Vulvar Carcinoma, metastatic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dire to for as a consequence of, Examine The law requires that the death certificate be executed physician and the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23e. Did tobacco use contribute to the cause of death? ð Hypertension 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No 24a. Was an certificate ha autopsy perform 2X No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospitał: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☒ No မ this 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred Certification: 28c. Injury at Work? After 5 Pending investigation 1 Natural 1 Yes 2 No 2 Accident within 24 hours after death

To the Funeral Director;
completely filled in by the 6 ☐ Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month

Tiffany Sanders,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

M.D.

14440 Cherry Lane Court, Suite 104

D0061586

October 30, 2006

20707

Laurel, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TIPM#31, perDVR, 0%01, 11/1/10, WS

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** Clyde W. Lewis 7:36a Oct 16, 2006 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner **Baltimore** MTC Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days 1 🗆 🗶 2 🗆 F Yrs. Director 219-16-8889 80 Oct 29, 1925 N.C Usual Residence of Decedent within 72 hours after deeth with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location in then "natural", or iteme 23a or 28a-f ehow the Medical Examiner must be notified at 1 ☐Yes 2 ☐ No **Baltimore** Director Md 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 301 McMechen U.S.A. 21217 Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐Xes 2 ☐ No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married 1945 Maryland 21215-0036 1 ☐ Yes 2 ☐ Xio Specify: Black Specify: 2 3 ☐ Widowed 4 ☐ Divorced 1945 Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 12 should be filed within 7 h and Mental Hygiene.
7 ie marked other then "n Elementary/Secondary (0-12) College (1-4or 5+) Carpenter & Caretaker 11 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) 86 Mary G. Nance permit. Pages 1 end 2 should be Deportment of Heelth and Menta Important: if item 27 ie marked eny linjury or other treumatic ev sncs. James Lewis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Claudette Lake Daughter 3306 Brighton Street Baltimore, Md 21216 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐Burial 2 ☐ Cremation 3 ☐ Removal from State 10/23/06 Baltimore, Md **Baltimore National Cemetery** 4 Donation 5 Other (Specify) 21. Signature of Fineral Service Lice 22. Name and Address of Facility Miller's Metropolitan Chapel 1639 North Broadway Baltimore, Maryland 21213 Part1. Enter the disease, or conshock, or heart failure. List only Approximate Interval Between Onset and Death prications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on eagh line. Immediate Cause (Final themia Physician disease or condition resulting in death) /Medical Due to for as a consequence of) Examiner neumonia Dicahur Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed attending physicien and for use es the burial-transit Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) P.O. 1 ed by the a 9 Unknown tor: After this certificete has been signed I the funeral director, page 2 should be det 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 1 Yes 2 No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death [Check only one] Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification; To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Mannef of Death 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 1 Natural 5 Pending 1 Yes 2 No death. investigation 2 Accident within 24 hours etter deat To the Funeral Director: 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) tilled in by 4 Homicide Hospitel 29s Certifier Cartifying Physician: To the best of my knowledge death occurred at the time date and close, and due to the cause(s) and manner as stated ompletely (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified laur ho completed cause of death (Item 23a) (Type, Print) 30. Name and address of person Salhmore 954 31. Date filed (Month, Day, State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. All No. 11,1106, WS

State of Maryland / Department of Health and Mental Hygiene 34678 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 330 ARLENE LABEZIUS 10 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number, 4b. City. Town, or Location of Death Examiner UPPER CHESAPEAKE BUI-AIR MD Hartord If Under 1 Year It Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Yea 1919 **Funeral** Months 1 □ M 2 X F Days Hours Min. 211-24-6835 - 86 Yrs. Director 12/06/-1916 Usual Residence of Decedent 10d. Inside City Limits r 28a-f show 10c. City, Town or Location 10a. State 10b. County 1 Yes XXNo Director MD. Harford JOPPA 10f, Zip Code 10g. Citizen of What Country? 10e. Street and Number permit. Pages 1 end 2 should be filed within 72 hours after death with Depertment of Health and Mental Hygiene.
Important: if item 27 is marked other then "naturel; or itema 23e or any injury or other treumatic event, the Medical Exemplant must be none. 3309 MOTHA Koad 21085 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ② No If Yes, Give Year or Dates: 14. Race - American Indian. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-It Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. X Never Married 2 Married White 1 ☐ Yes 2 No Specify: Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) | 30 | 0 6 | 1 3 5 | 1 3 5 | 1 3 5 | 1 3 5 | 1 3 5 | 1 3 5 | 1 3 5 | 1 3 5 | 1 3 5 | 1 3 5 | 1 3 5 | 1 3 5 | 1 3 5 | 1 3 5 | 1 3 5 | 1 3 5 | 1 3 5 | 1 3 5 | 1 3 5 | 1 3 5 | 1 3 5 | 1 3 5 | 1 3 5 | 1 3 5 | 1 3 5 | 1 3 5 | 1 3 5 | 1 3 5 | 1 3 5 | 1 3 5 | 1 3 5 | 1 3 5 | 1 3 5 | 1 3 5 | 1 3 5 | 1 3 5 | 1 3 5 | 1 3 5 | 1 3 5 | 1 3 5 | 1 3 5 | 1 3 5 | 1 3 5 | 1 3 5 | 1 3 5 | 1 3 5 | 1 3 5 | 1 3 5 | 1 3 5 | 1 3 5 | 1 3 5 | 1 3 5 | 1 3 5 | 1 3 5 | 1 3 5 | 1 3 5 | 1 3 5 | 1 3 5 | 1 3 5 | 1 3 5 | 1 3 5 | 1 3 5 | 1 3 5 | 1 3 5 | 1 3 5 | 1 3 5 | 1 3 5 | 1 3 5 | 1 3 5 | 1 3 5 | 1 3 5 | 1 3 5 | 1 3 5 | 1 3 5 | 1 3 5 | 1 3 5 | 1 3 5 | 1 3 5 | 1 3 5 | 1 3 5 | 1 3 5 | 1 3 5 | 1 3 5 | 1 3 5 | 1 3 5 | 1 3 5 | 1 3 5 | 1 3 5 | 1 3 5 | 1 3 5 | 1 3 5 | 1 3 5 | 1 3 5 | 1 3 5 | 1 3 5 | 1 3 5 | 1 3 5 | 1 3 5 | 1 3 5 | 1 3 5 | 1 3 5 | 1 3 5 | 1 3 5 | 1 3 5 | 1 3 5 | 1 3 5 | 1 3 5 | 1 3 5 | 1 3 5 | 1 3 5 | 1 3 5 | 1 3 5 | 1 3 5 | 1 3 5 | 1 3 5 | 1 3 5 | 1 3 5 | 1 3 5 | 1 3 5 | 1 3 5 | 1 3 5 | 1 3 5 | 1 3 5 | 1 3 5 | 1 3 5 | 1 3 5 | 1 3 5 | 1 3 5 | 1 3 5 | 1 3 5 | 1 3 5 | 1 3 5 | 1 3 5 | 1 3 5 | 1 3 5 | 1 3 5 | 1 3 5 | 1 3 5 | 1 3 5 | 1 3 5 | 1 3 5 | 1 3 5 | 1 3 5 | 1 3 5 | 1 3 5 | 1 3 5 | 1 3 5 | 1 3 5 | 1 3 5 | 1 3 5 | 1 3 5 | 1 3 5 | 1 3 5 | 1 3 5 | 1 3 5 | 1 3 5 | 1 3 5 | 1 3 5 | 1 3 5 | 1 3 5 | 1 3 5 | 1 3 5 | 1 3 5 | 1 3 5 | 1 3 5 | 1 3 5 | 1 3 5 | 1 3 5 | 1 3 5 | 1 3 5 | 1 3 5 | 1 3 5 | 1 3 5 | 1 3 5 | 1 3 5 | 1 3 5 | 1 3 5 | 1 3 5 | 1 3 5 | 1 3 5 | 1 3 5 | 1 3 5 | 1 3 5 | 1 3 5 | 1 3 5 | 1 3 5 | 1 3 5 | 1 3 5 | 1 3 5 | 1 3 5 | 1 3 5 | 1 3 5 | 1 3 5 | 1 3 5 | 1 3 5 | 1 3 5 | 1 3 5 | 1 3 5 | 1 3 5 | 1 3 5 | 1 3 5 | 1 3 5 | 1 3 5 | 1 3 5 | 1 3 5 | 1 3 5 | 1 3 5 | 1 3 5 | 1 3 5 | 1 3 5 | 1 3 5 | 1 3 5 | 1 3 5 | 1 3 5 | 1 3 5 | 1 3 5 | 1 3 5 | 1 3 5 | 1 3 5 | 1 3 5 | 1 3 5 | 1 3 5 | 1 3 5 | 1 3 5 | 1 3 5 | 1 3 5 | 1 3 5 | 1 3 5 | 1 3 5 | 1 3 5 | 1 3 5 | 1 3 5 | 1 3 5 | 1 3 5 | 1 3 5 | 1 3 5 | 1 3 5 | 1 3 5 | 1 3 5 | 1 3 5 | 1 3 5 | 1 3 5 | 1 3 5 | 1 3 5 | 1 3 5 | 1 3 5 | 1 3 5 | 1 3 5 | 1 3 5 | 1 3 5 | 1 3 5 | 1 3 5 | 1 3 5 | 1 3 5 | 1 Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Harry Labezius Nora Stokes 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Barry Labezius/nephew 120 Indian Hill Rd. Conestowga, PA 17516 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Chesapeake Crematory 11/01/06 MD Beltsville, 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility CAFA MOJYU3 8717 Green Pastures Dr. Balt. MD 21286 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) hysician /Medical Examiner Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner cate has been signed by the attending physicien and 🧖 page 2 should be detached for use as the burial-transit Due to (or as a consequence of) ician/Medical IF FEMALE: 23c. tf yes, outcome of pregnancy
1 Live birth 2 Fetat death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? Month 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an certificate has autopsy performed? 1 Yes 2 DNO filled in by the funeral director, 25. Was case referred to medical 26. Place of Death | Check only one examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3□ DOA After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending Injun 1 ☐ Yes 2 ☐ No death. investigation ofter death 2 Accident 6 Could not be determined 3 Suicide 28t. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, tarm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital o within 24 hours eff To the Funeral D completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and titte of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) ess of person who completed cause of death (trem 23a) (Type, Print) 3 500 Upper Chesapeake Drive Beldic, MD 21014 Nesreen wtom 32 Registrar's Signature 31. Date filed (Month, Day, Year) State NOV 0 2006

DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygien [ ] [ ] [ For State Registra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year **Physician** Virginia Elizabeth Leonard 8:27 A October 30, 2006 /Medical 4b. City. Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Harford Memorial Hospital Havre de Grace Harford If Under 1 Year | If Under 24 Hrs Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral 1 □ M 2 □ XF Yrs. Director 213-26-2382 1929 Maryland Usual Residence of Decedent 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits 28e-1 ehow traumatic event, the Mudical Examiner must be notified at 1 ☐ Yes 2 ☐ No Directo Maryland Harford Havre de Grace 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 5 704 Pulaski Hwy. Terrace Gardens Apt.2 21078 Items 23a USA death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2∑No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. Black, White, etc. filed within 72 hours after 1 Never Married 2 ☐ Married 9 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify. Completed by 3 XWidowed 4 ☐ Divorced White "natural" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Packer Shoe Manufacturing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 12 should be fi and Mental H is marked of Jre, Maryla Jermit. Pages 1 and 2 should be be Department of Health and M-Important: If Item 27 -any Injury or r ဂ္ Paul Elmer Cantler Nellie Elizabeth Beavers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 610 Ilse Dr., Newark, Delaware 19713 ce of Disposition (Name of 20c. Location-Larry Thompson/Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Hilltop Service Corp. 11-1-06 4 ☐ Donation 5 ☐ Other (Specify) Towson, Maryland McComas Funeral Home, P. A. 23a. Part1. Enler the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 1317 Cokesbury Rd., Abingdon, Maryland 21009 Approximate Interval Between Onset and Death Immediate Cause (Final Stage Du monas Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) The law requires that the death certificate be executed use as the burial-transit Exam that initiated events resulting in death) Last attending physicien and Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Day Year 4 Pregnant at time of death 5 Other (specify) ed by the a 1 ☐ Yes 2 ☐ No 9☐ Unknown 9 Unknown hed by Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş Division of Vital Records, should be o 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 1 Yes 2 No 1 ☐ Yes 22 No Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient Medical Certification: To 3□ DOA this 28a. Date of Injury (Month, Day Year) After thi 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation М s after death the 6 ☐ Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) filled in by 4 Homicide ō within 24 hours a To the Funerel E Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only one) the 29b. Signature and Otte of certifier 2006 October 31 1 Name and address of person who complete pause of death (Item 23a) (Type, Print) 1308 BUSINSS

State Registrar

NOV 0 1 2006 DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 5 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Daylh **Physician** Month 28 2006. 4c. County of Death HAROLD OCTOBER /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death NORTHWEST HOSPITAL CENTER RANDALLSTOWN BALTIMORE 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Funeral Age (In yrs. last birthday) Birthplace (State or Foreign Country) Director 213-30-7113 90 08/29/1916 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location r than "natural", or itama 23a or 28e-f ahow the Medical Examinar must be notified at 10d. Inside City Limits MD BALTIMORE Funeral Director BALTIMORE 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 725 MT. WILSON LANE 21208 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No If Yes, Give X Year or Dates: Baltimore, Maryland 21215-0036 Completed by 1 ☐ Yes 2 X No Specify: 3 ☐ Widowed 4 ☐ Divorced WHITE 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry marked other than Elementary/Secondary (0-12) College (1-4or 5+) **PROPRIETOR** LESTER FOOD MARKET 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) if Health and Mental MORRIS **LESTER** REBECCA ADLEBERG 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MICHELLE 2315 TUFTON SPRINGS LANE - RESITERSTOWN, MD 21136 WINIK 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Pages Department of Important: If It any injury or or 1 Burial 2 Cremation 3 Removal from State 4 Onation 5 Other (Specify) ARLINGTON CHIZUK AMUNO 10/31/2006 BALTIMORE, MD 21. Signature of Funeral Service License 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician CEREBROVASCULAR THROMBOSIS 1-1 CLITE /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last ADVANCE Due to (or as a consequence of) Examine physicien and s the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery jo 3 Ectopic pregnancy in the past 12 months? 4□Pregnant at time of death Dav Year 5 Other (specify) detached 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 23e. Did tobacco use contribute to the cause of death? page 2 should be 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No autopsy 2 18 No 2 No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Certification; To 1 ☐ Yes 2 No Other: 1 CInpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending Diractor: 2 Accident investigation 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 041410 28 October JOGINDER P 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MEHTA MILIZOFE MORTHWEST CENTER RANDAUSTOWN MD 31. Date filed (Month, Day, Year) 32 Registrar's Signature State 2006 Registrar DHMH 17 Rev 1/2001

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	Examin	er	HARBOR HOSPI		TER			HORE		N/A	atti		
	Funeral Director		5. Social Security Number 6. Se		e (In yrs. last birtl	nday) If Under Months		Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, April 22	9 B	irthplace (State or Foreign Country) Ew York		
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9	should be filed within 72 hours after death with the Maryland of Mental Hygiene. The marked other than "netural", or items 23a or 28a-f show marked other than "netural", or items 23a or 28a-f show maric event, the Medical Examination out the indifficulation.	y Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Armed Forces? 1 X Yes 2 1 If Yes, Give	No	13. Was Deced	ify Cuban,	anic Origin? (Sp Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - An Black, Wh Specify: W	ite, etc.		
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II.			23a. Part1. Enter the disease, or composhock, or heart failure. List only o	lications that caused ne cause on each li	i the death. Do n ne.	ot enter the mode	of dying, s	such as cardiac	or respiratory arre	st,	Approximate Interval Between Onset and Death		
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Funeral Director		212-20 2710	TM 0000	hday) If Under 1 Year If Under 24 Hrs Months Days Hours Min.	8. Date of Birth (Month, Day, 07 2.	<sup>Year)</sup> 46	Birthplace (State or Forei Country) MD		
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ind Mental Hygi marked other umatic event, I	To Be C	17. Father's Name (First, Middle, Last) Ernest Smith		18. Mother's Nai Mary	me (First, Middle, M Banks	Maiden Sumame)			
7 In		19a. Informant's Name/Relationship (Ty Beatrice Matthe	`	Mailing Address (Street and Number or Ri 812 Ford Lane, B			e, <i>Zip Cod</i> e) 2 <b>1215</b>		
t of Health If item 27 or other tr		20a. Method of Disposition 1 □ Burial 2 □ remation 3 □ F	20b. Place of	Disposition (Name of y, crematory or other place)	Date	20c. Location - City	or Town, State		
ant:		4 □ Donation 5 □ Other (Specify)  21 For the of Funeral Service Licens	Metro	Crematory Inc 10	0/30/06	Baltin	more, Md		
Departi Importa eny Inj		> Small ()	Might	March <sup>nd</sup> for the West 4300 Wabash Ave	, Balti	more, Mo	21215		
nysician		23a. P. rt1. Enter the disease, or complete nock, or heart failure. List only of limits late Cause (Final disease or condition	ications that caused the death. Do not not cause on each line.	ot enter the mode of dying, such as cardia	or respiratory arre	est,	Approximate Interval Between Onset and Death		
Medical xaminer	1	refulting in death)	a Due to (or as a consequence of Limb	on: lechowia					
	je	Sequentially list conditions,	Due to (or as a consequence of	of:					
hysicien and the burial-transit	i Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of	of):					
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by the attending physicien and tached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. tf yes, outcome of pregnancy  1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of Month	delivery Day Year		
gned by be detac	by Ph	Part II. Other significant conditions con	ntributing to death but not resulting in	the underlying cause given in Part I.	23e. Did tob	pacco use contribut	e to the cause of death?		
been sig should b					1 🗆 Ye	as 2 <b>Z</b> H√o 3 □	Probably 4 Unkno		
ate has page 2	Completed	OF Warrant and American			24a. Was an autops perform	y prior ned? death 2 □ No 1 □ \			
is cer direc	To Be	25. Was case referred to medical examiner?  1 Yes 2 No	lospital: 1 ☑Inpatient 2 ☐ ER/Out	Othor	ath (Check only on Iome 5 - Reside	e <i>)</i> ence 6 ∐Other <i>(S</i>	Брөсіfу)		
Afte	Certification;	27. Manner of Death  1 PNatural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be		njury Work?  M 1 Tyes 2 No		ow injury occurred			
within 24 hours after death To the Funerel Director: completely filled in by the		4 Homicide determined	28e. Place of Injury - At home, far building, etc. (Specify)		City or Town	n, State)	r Rural Route Number,		
n 24 hours a ne Funeral I	Medical	29a. Certifier 1 Certifying Phy (Check only one)	sicien: To the best of my knowledge her: On the basis of examination and and manner stated.	, death occurred at the time, date and place for investigation, in my opinion, death occurrences	a, and due to the ca irred at the time, da	ause(s) and manner ate and place, and o	r as stated. due to the cause(s)		
within 2 To the complete	¥	29b. Signature and title of certifier	C. Smlt, XI	Type, Print)  29c. License number  DOS 29c.  Type, Print)  Amon	50	9d. Date signed (M.) Oct 18	onth, Day, Year)		

State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No.Z Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year Fidele E. Martino **Physician** October 27, 2006 10:15 AM /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 15115 Interlachen Dr. #424 Examiner Silver Spring Montgomery 7. Age (In yrs. last birthday) | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 04/01/1926 5. Social Security Number 037-14-0718 6. Sex Birthplace (State or Foreign Country) **Funeral** 187M 2□ F Director NY Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits itam 27 is marked other than "natural", or items 23s or 28s-f show other traumatic avant, the Medical Examiner must be notified at MD Montgomery 1 Yes 2 No Silver Spring Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 15115 Interlachen Dr. #424 20906-United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 III No Specify: Specify: 2 3 Widowed 4 Divorced White Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Insurance I Hygiene. Elementary (Secondary (0-12) College (1-4or 5+) Salesman 17. Father's Name (First, Middle, Last)
Donato Martino 18. Mother's Name (First, Middle, Maiden Sumame) . Pages 1 and 2 should be fill timent of Health and Mental H tant: If Itam 27 is marked oth jury or other traumatic avan Candida Mele 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print)
Maxine W. Martino/Wife 15115 Interlachen Dr. #424 Silver Spring, MD 20906 20b. Place of Disposition (Name of cemetery, crematory or other place) Oct 31 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Chesapeake Crematory permit. Page Department of Important: If any injury or once. Beltsville, Maryland 2006 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22 Rapp and Address of Facility Cremation Services MO0382 933 Gist Ave. Silver Spring, Maryland 20910-Me Don Dohunaum 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Myocardial Infarction **Physician** /Medical resulting in death) Due to (or as a consequence of): Examiner High Grade Sarcoma Sequentially list conditions Due to (or as a consequence of). Examiner is any, leading to immediate cause. Enter Underlying Cause (Disease or injury and The law requires that the death certificate be executed attending physicien and K Coronary Artery Desease that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day 4☐Pregnant at time of death 5 Other (specify) signed by the a d be detached for 1 ☐ Yes 2 ☐ No 9 Unknown 9 Dunknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown Pulmonary Emboli should 24b. Were autopsy findings available prior to completion of cause of death? Prostate Cancer 24a. Was an page 2 autopsy performed? certificate 1 ☐ Yes 2 ☐ No 1 Yes 2X No 124 hours after death. • Funeral Diractor: After this certific letely filled in by the funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No ဥ 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Jedicai Certification: 5 Pending investigation Hospital or Attending 1 X Natural 1 ☐Yes 2 ☐No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicid 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier completely and manner stated. within 2 류 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and the 2 OCT. 30, 2006 150030 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) David Rogers M.D.; 5530 Wisconsin Ave., Chevy Chase, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature NOV 0 1 2006 Registrar

State of Maryland / Department of Health and Mental Hygiene 34684 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month **Physician** Alyce Theresa Marshall October 27, 2006 6:30 a /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 1216 Glenville Road Harford Churchville If Under 1 Year | If Under 24 Hrs. 8. Date of Birth | Months | Days | Hours | Min. | (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 💢 F Director 215-14-4378 83 Apr. 18, 1923 Maryland Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10b. County 10d. Inside City Limits work i rthen "naturel", or flems 23a or 28a-f shov the Medical Examinar must be notified at 1 Yes 2 No Directo Maryland Harford Churchville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1216 Glenville Road 21028 death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: þ Specify: 3₺ Widowed 4 Divorced Year or Dates: White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Commercial Loan Officer Banking permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Itsm 27 Is marked othe any injury or other traumatic event, once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame, Be James (nmn) Leverton Bertha Katherine Kral ဂ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1216 Glenville Road, Churchville, Maryland 21028 Son William R. Marshall III / 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 10-31-06 4 Donation 5 Other Specky) / Bel Air Memorial Bel Air, Maryland 22. Name and Address of Facility McComas Funeral Home, P. A. 50 West Broadway, Bel Air, Maryland 21014 complications that unit only one cause on Approximate Interval Between Onset and Death caused life death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition Subnuclear Pals **Physician** Due to (or as a consequence of): /Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physicien and for use as the burial-transit Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Year 4 Pregnant at time of death 5 Other (specify) signed by the a d be detached for 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. ģ should be 1 ☐ Yes 2 No 3 Probably 4 □Unknown Completed peeu 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? page 2 autopsy 1 Yes 2X No director. Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) မှ 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA in by the funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Alter 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident after death 6 Could not be 3 ☐ Suicide 28e. Place of Injury · At home, larm, street, lactory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide To the Hospital 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie within 24 hou To the Fune completely file Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D28489 10/27/06 completed cause of death (Item 23a) (Type, Print), Del Par Md 20 14. 30. Name and address of person who completed 10 32 Registrar's Signature 31. Date liled (Month, Day, Year) State Registrar NOV 0 1 2006

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 34685 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** James McDuffy, Jr. 21, Oct. 2006 7:00 am /Medical 4a. Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Saint Thomas Moore Nursing & Rehab. Center Prince George's Hyattsville 7. Age (In yrs. last birthday) If Under 1 Year if Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplece (State or Foreign
Country) 5. Social Security Number 6. Sex 1X M 2 □ F **Funeral** Hours Country) North Carolina Months Days 67 Director 243-50-4998 12-12-1938 Usual Residence of Decedent parmit. Pagas 1 end 2 should be filed within 72 hours after death with the Maryland Dapartment of Health and Mantal Hygiane.
Important: If item 27 is marked other than "netural" ery hijury or other traumatic even and the set in the content of the content of the content in the 10c. City, Town or Location 10d. inside City Limits 10a State 10b. County 1 X Yes 2 □ No Washington D.C. Director 10g. Citizen of What Country? 10e. Street end Number 10f. Zip Code 1489 Newton Street #44 20010 U.S.A. Funerai 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Black Specify: δ 3 Widowed 4 □ Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) DC Public School 12th Engineer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mary Smith James McDuffy, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1489 Newton Street, N.W. #44 Washington, D.C. 20010 19a. Informant's Name/Relationship (Type, Print) Angela McDuffy/Daughter 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ⊠ Burial 2 □ Cremetion 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Glenwood Cemetery 10/28/06 Washington, D.C. 22. Name and Address of Facility W.H. Bacon Funeral Home, Inc. 21. Signature of Funeral Service Licensee 3447 14th Street, N.W. Washington, D.C. 20010 CC 361 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Death **Physician** . Arteriocoferotic Candiovascular Diseas Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or as a consequence of): Examiner attanding physician end for usa as the burial-transit Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest Due to (or es e consequence of): Division of Vital Records, P.O. Box 68760 by Physician/Medical Due to (or as e consequence of): 23b. Did tobecco use contribute to the causa of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Was en eutopsy performed? Completed 1 ☐ Yes 2 No 1 Tyes 2 1 No spital or Attending Physician: Thours aftar death.
neral Director: After this certificati 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 1 Yes 2 No ٩ 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 T Homicide To the Hospital c within 24 hours at To the Funeral D completaly filled i 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

State Registrar 30. Name

31. Date filed (Month, Day, Year)

NOV 0

end address of person who completed cause of death (Item 23a) (Type, Print)

2006

#### 06-08146

Michael D Nazarenus

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygic

		Registrar	ertificate of Death	2006 01 0
Physi Medical Exa	ciar nine	1. Decedent's Name (First, Middle,Last)  Michael Daniel Nazarenus		Reg No  2. Date of Death Month Day Year  3. Time of Death
(1)		4a. Facility Name (if not institution, give street and number) University Hospital	4b. City, Town, or Location of Deal	
Funera			Baltimore City  last birthday) If Under 1 Year If Under 24Hr	Baltimore  8 Date of Birth (AMADDAYAVA) & Dat
Directo	r	F	Yrs. Months Days Hours Min	- OC TOE TAGE OF POTEN
vany		Usual Residence of Decedent  10a State	y. Town or Location	10d Inside City Limits
ryland a-f shov	غ ا		Baltimore	1 X Yes 2 No
MD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene 27 is unarked other than "natural", or items 33a or 28a-f show any matic event, the Medical Examiner must be notified at now	Director		10f. Zip Code 21223	10g. Citizen of What Country? United States
death wj	Funeral	11. Marital Status 1 Never Married 2 Married Armed Forces? 1 Yes 2 No	U.S. 13. Was Decedent of Hispanic Origin? (S	pecify Yes or No- Rican, etc.)  14. Race - American Indian, Black, White, etc.
rs after ural", o	3	3 Widowed 4 Divorced If Yes, Give Year or Dates:	1 Yes 2 X No specify	Specify: White
6 72 hou in "nati	leted	15 Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4 or 5+)	16a. Decedent's Usual Occupation (Give kind of during most of working life DO NOT use reti	work done 16b Kind of Business/Industry red)
5-0036 led within 72 hours after Hygiene other than "natural", the Medical Examiner	Completed	17 Father's Name (First Middle Lept)	Disabled	Disabled
21215-0036 Build be filed within 7 Mental Hygiene unarked other than event, the Medica.	8	riederick E. Nazarenus	18 Mother's Name Mary Dor	(First, Middle, Maiden Surname)
MD 2 d 2 should lth and M n 27 is un	မ	19a Informant's Name/Relationship (Type, Print) Frederick E. Nazarenus, II/Broth	19b. Mailing Address (Street and Number or F	Rural Route Number, City or Town, State, Zip Code)
tr te a s		20a Method of Disposition	Place of Disposition (Name of cemetery,	Date 20c. Location - City or Town, State
Baltimore, permit Pages I ar Department of Hee Important: If ite	١.	1 XBurial 2 Cremation 3 Removal from State Cec		2/2006 Brooklyn Park, MD
Ba perm Depa Impo		Lind Since	1 10 MILICELLS AVEIN	bbard Funeral Home, Inc. e, Baltimore, Maryland 21229
Physician /Medical		23a Part I. Enter the disease, or complications that caused the death failure. List only one cause on each line.	. Do not enter the mode of dying, such as cardiac or	respiratory arrest, shock, or heart Approximate Interval
Examiner		Immediate Cause (Final disease or condition resulting in death)  Hypertensive atlanded but to (or as a consequence of the condition of the con	nerosclerotic cardiovascular o	lisease Death
	Jer	Sequentially list conditions, if any, leading to immediate	fl:	
tl	Examine	cause Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence or		9
ecords, P.O. Box 68760, he law requires that the death certificate be executed at the been signed by the attending physician and age 2 should be detached for use as the burial - transi		d		
8760, tificate be ex ng physician as the burial	n/Medical	#4c,23a,27	7, perME, g862, 12/7/06 TT	
Sox 687 leath certific e attending p	sician	past 12 months?  1 Live birth Pregnant at time of decorated by the second secon	2 Fetal death 3 Ectopic pregnan	23d Date of delivery  Month Day Year
the death c by the atten	Phys	1 Yes 2 No 9 Unknown 9 Unknown	other (Specify)	
s, P.O.	2	Part II. Other significant conditions contributing to death but not re	esulting in the underlying cause given in Part I.	23e Did tobacco use contribute to the cause of death?  1  Yes 2 ✓ No 3  Probably 4 Unknown
Division of Vital Records, tal or Attending Physician: The law requirers after death all Director: After this certificate has been sited in by the funeral director, page 2 should be a sh	Completed			24a. Was an 24b Were autopsy findings available
<b>6</b> ⊢ 3 a		25. Was case referred to medical		autopsy prior to completion of cause of death?  1 Yes 2 No 1 Yes 2 No
Vita hysician this cer	o Be	examiner?	26 Place of Death (Check or ER/Outpatient 3 DOA Other Nursing	
on of \alpha of \alpha of \text{ading Ph}; th :: After the funeral	ie E	27 Manna of Death	28b. Time of Injury 28c. Injury at Work? 2	Home 5 Residence 6 Other.  8d. Describe how injury occurred
Division pital or Attentours after deatheral Director:	Certification:	2 Accident Investigation	ne, farm, street, factory, office building, etc.	RELIGION (Circuit and I
Ospital hours a uneral		4 Homicide determined (Specify)		Bf Location (Street and Number or Rural Route Number, City or Town, State)
Division of Vital  To the Hospital or Attending Physician: within 24 hours after death To the Funeral Director: After this certif completely filled in by the funeral director.	1 20	one) Certifying Physician: To the best of my knowledge one) 2 Medical Examiner: On the basis of examination and	e, death occurred at the time, date and place, and dud/or investigation, in my opinion, death occurred at the	ue to the cause(s) and manner as started ne time, date and place, and due to the cause(s)
F > F 0	ž	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
		Name and address of person who completed cause of death (Item 2	O.C.M.E.	October 30, 2006
		Ling Li, MD Assistant Medical Examiner 111 F	Penn Street, Baltimore, MD 21201	
Sta Registi	ite ar	31. Date filed (Month, Day, Year)  NOV 0 1 2006	book	
HMH 17 Rev 1/20				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Doarthy Isabelle Green Nea1 October 30, 2006 2:30AM M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 3023 Tucker Road Fort Washington Prince George's If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 1 □ M 2 및 F 579-66-9252 96 Director Sept. 22,1910 Canada Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show ral", or items 23a or 28a-f shov Examiner must be notified at Maryland Prince George's 1 ☐ Yes 2 ☐ No Fort Washington Director 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 3023 Tucker Road 20744 U.S.A. Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 11. Marital Status Black, White, etc 1 ☐ Never Married 2 ☐ Married White 1 ☐ Yes 2 ☐ No 3 Widowed 4 ☐ Divorced Year or Dates 'natural", 16a. Decedent's Usual Occupation the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Home 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Robert Jackson Green Jennie Elizabeth Hayes 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Janet Smith (Daughter) 8607 Dangerfield Road Clinton, Maryland 20735 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Maryland Veterans Cem. 2006 Cheltenham, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur 22. Name and Address of Facility Lee Funeral Home, Inc. 6633 Old Alexandria Ferry Road Clinton, MD 20735 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cardio Megal L **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner use as the burial-tran Due to (or as a consequence of): physician Completed by Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 4☐Pregnant at time of death 5 Other (specify) signed by the at d be detached fo 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed' 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5X Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No ၉ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: or Attending 5 Pending investigation 1 XXXaturai 1 Yes 2 No death. 2 ☐ Accident

P.O. Box 68760, The law requires that the death certificate be or Vital Records,

Division

Hospital

Baltimore, Maryland 21215-0036

within 24 hours after death

To the Funeral Director;
completely filled in by the

6 ☐ Could not be 3 Suicide

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

4 ☐ Homicide

29a. Certifier

determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

Khosrow Davachi, MD 7801 Old Branch Avenue #409 Clinton, Maryland 20735

Registrar

NOV 0 2006 32. Begistrar's Signature

			For State Registrar	State of Maryland		artment of H			giene 006	34688
	Physici		Decedent's Name (First, Middle, Last)     Lisa	s.		Nelson		2. Date of Dea Month 10	ath Day Year	3. Time of Death
Я	/Medio Examir		4a. Fecility Name (If not institution, give s Joseph Richy Hos				Location of Death		4c. County of De	
	Funeral Director		219-00-2197	7. Age (In yrs. Ia	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da)	y, Year)	irthplace (State or Foreign Country) Md
	Maryland B-f ehow	tor	Usuel Residence of Decedent  10a. State  10b. County  Md.  NA		Town or Lo					10d. Inside City Limits 1   Yes 2 □ No
	h with the 23a or 28	ai Director	10e. Street and Number 2332 Reistertown	Road		10f. Zip Code 212	17		10g. Citizen of What C USA	•
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "naturel", or iteme 23e or 28e-f show says injury or other traumatic event, the Medical Exaction must be ricitlised at ODEs.	by Funerai	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☐ Widowed 4 ☐ Divorced	<ul> <li>12. Was Decedent Ever in U.S Armed Forces?</li> <li>1 ☐ Yes Z∑ No If Yes, Give Year or Dates:</li> </ul>	!	Was Decedent of Hi f Yes, specify Cuba 1 ☐ Yes 2X No	ispanic Origin? (Sp. Mexican, Puerto Specify:	Decify Yes or No- o Rican, etc.)	14. Race - Am Black, Wh Specify: B	ite, etc.
Maryland 21215-0036	l within 72 ho iene. r than "natur the Medical.	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) 12th grade		(Give life. l	tent's Usual Occupa kind of work done of DO NOT use retired sing Assi	during most of wor !)	king	16b. Kind of Busines Healthy	
land	uld be filed fenta! Hyg rked other IIC event,	To Be C	17. Father's Name (First, Middle, Last) Ralph	Gil	liam			ne (First, Middle, nise	Maiden Sumame) Nels	son
, Mary	and 2 should like the sailth and No. 27 is maner or trauma		19a. Informant's Name/Relationship (Ty) Ralph Gilliam	Poo, Print) Father					or, City or Town, State, Parkville,	
altimore,	Pages 1 ament of He ant: If item ury or oth		20a. Method of Disposition 1. Burial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify)	emoval from State	ace of Dispo metery, crem ng Mem	sition (Name of natory or other place)  • Pk.	I	Date -2-06	20c. Location - City o	121
Balt	permit. Departimport eny inj		21. Signature of Funeral Service Ligense  Sement M The				North Av	re., Balt	F.H. East timore, Md	. 21202
8760,	death certificate be executed  Ex  Medicular  Manual	dicai Examiner	23a. Part1. Enter the disease, or complications, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of the total or as a consequence or as a consequence of the total or as a consequence or as a consequence of the total or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a c	ence of):					Approximate Interval Between Onset and Death
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rds, P.	w requires thet the been signed by th should be detache	Ď	Part II. Other significant conditions con	tributing to death but not resu	Iting in the ur	nderlying cause give	en in Part I.		obacco use contribute 'es 2 □ No 3 □ F	to the cause of death? Probably 4 Sunknown
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ō	or Attending Physicien: The Is after death. Director: After this certificate has in by the funeral director, page 2	Certification: To Be	27. Mann of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could n. be	ospital: 1 Inpatient 2 E  28a. Date of Injury (Month, Day Year)  28e. Place of Injury - At hor	28b. Time of Injury	28c. Injury Work M 1 🗆 V	4 Li Nursing H	ome 5 ☐ Resid 28d. Describe h	/	Magne
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	3		30. Name and address of perso, who	m I ted cause of death (Item	23a) (Typ-	Print)	no Fr	1 fix	to Mil	21210
K	Sta Registr		31. Date filed (Month Say, Year), 20(	6 32 légistrate Signat	1	artie	4	12.04/	7/14	W/ D/ J

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	10		30. Name and address of person who	completed cause of	death (Item 23a) (Type,	•	uso car	DAIMAG	26 410	215	
	Sta	ite	ABHISHES SRI 31. Date filed (Month, Day, Year)		rar's Signature		ILE 31.	BALTMO	-E, MU	212	<del>دے</del>
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	Physici /Medic	al	Mildred E	. Procto	R		10	20 00	11112
	Examin	er	4a. Facility Name (If not institution, give s	Hospital Cente	P Clinton	r Location of Death	)	4c. County of Death	
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	yland		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town	or Location				10d. Inside City Limits
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36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Iteme 23e or 28e-f show amy fortury or other treumatic event. The Medical Examinar must be notified at once.	Completed by Funeral Director		12. Was Decedent Ever in U.S. Armed Forces?  1  Yes 2 No If Yes, Give Year or Dates:	13. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ∰ No	lispanic Origin? (Sp	pecify Yes or No- Rican, etc.)	14. Race - Amer Black, White	ican Indian, , etc.
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Maryland 21215-0036	hould to d Ment marked matic e	P	Robert W. Har		Mailing Address (Street		la Proct		0.11
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Division of Vital Records,	at or Attens s after dea	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, far building, etc. (Specify)	m, street, factory, office		28f. Location (Sti City or Town	reet and Number or Run n. State)	al Route Number,
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	To t To t	Σ	29b. Signature and title of certifier		29c. License		1	9d. Date signed (Month,	
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	8		30. Name and address of person who con  Soly THERD MARN  31. Date filed (Month, Day, Year)	LAND AV (P) TAL	CENTER	7503 5	CURRAT	TTI DO CL	INTUN AD
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Signature	Roule 8				2073

State of Maryland / Department of Health and Mental Hygiene 34691 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day MARIALUISA ALVAREZ POBLADOR October 28, 2006 8:30 /Medical 4e. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 8807 Barnsley Court Laurel Prince George's If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, May 30, 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 🗌 M 216-68-1648 74 Philippines Director 1932 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director Prince George's Laurel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or Itams 23a or 8807 Barnsley Court #21 20708 Philippines death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ②No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Pacific 1 ☐ Yes 2 No þ Specify: 3 ☑ Widowed 4 ☐ Divorced Year or Dates: "natural" Islander Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than Elementary/Secondary (0-12) College (1-4or 5+) years Sales Jewelery other permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: If tiem 27 is marked oth any jury or other traumatic svent 90cg. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Ramon Alvarez (unknown) Echon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mario L. Poblador son 9007 Giltinan Court Springfiled, VA 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State West Arundel Crematory 11/7/2006 1 4 ☐ Donation 5 ☐ Other (Specify) Odenton, Maryland 21. Signature of Funeral Service Licensee 22 Name and Address of Facility Donaldson Funeral Home, P.A. 4 →/ M00770 313 Talbott Avenue Laurel, Maryland 20707 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death shock, or heart failure. Immediate Cause (Final disease or condition resulting in death) **Physician** Cardiac Arrest /Medical Due to (or as a consequence of) Examiner Acute Myocardial Infarction Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner To the Hospital or Attanding Physician: The law requires that the death certificate be executed Chronic Hypertension and burial-1 Due to (or as a consequence of): Sician Box 68760 Physician/Medical the phys IF FEMALE: esn 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 | Fetal death 3 Ectopic pregnancy ğ in the past 12 months? 1 ☐ Yes 2 ② No Day Year 4□Pregnant at time of death 5 Other (specify) o. the 9 Unknown مَ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ cate has been signated by page 2 should by 1 Yes 2XNo 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe icate 1 Yes 1 ☐ Yes XX No 2 X X o Be 25. Was case referred to medical examiner? certifi 26. Place of Death Check on one Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🛛 📉 o ဥ his 28a. Date of Injury (Month, Day Year) Certification: 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After 1 X Xatural 5 Pending death. I Director: / investigation 1 □ Yes 2 □ No 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral C 1 XX ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Dav. Year) Q D 0013689 October 30, 2006 adr Thosan 30. Name and iddress of person who completed cause of death (Item 23a) (Type, Print) 13900 Baltimore Blvd. Mirza Baig, M.D. Laurel, Maryland 31. Date filed (Month, Day, Year) NOV 0 1 2006 32. Registrar's Signature State Registrar

			For State	State of Maryl		partment of H ertificate of L		Mental Hy	-	1116	34692
			Registrar  1. Decedent's Name (First, Middle, Las	**		erinicate or L	Jeani	2. Date of D	Reg. No.	. 0 0 0	3. Time of Death
	Physicia	an						Month	Day		5:23 AM
	/Medic	al	EDWAND PAWLI			4b. City, Town, or	Location of Death	OCTOBE	-	County of Death	3.27 7
	Examin	er		BAYVIRW CH	a, hea		LLTI MOR		40.	,	I/A
			5. Social Security Number 6. Si		yrs. last birthda		If Under 24 Hrs.	_ :	rth		
	Funeral Director			ØM 2□F 82	Yrs	Months Days	Hours Min.	June 1	ay, Year) . <b>0 . 1</b> 9:	24 Mary	place (State or Föreign ntry) rland
			Usual Residence of Decedent	02						*	
	yland		10a. State · 10b. County	10c	. City, Town or	Location					10d. Inside City Limits
	Marie I	tor	Maryland Bal	timore				Dunda1	.k		1 ☐ Yes 2 🖾 No
	th the	Director	10e. Street and Number			10f. Zip Code			10g. Citi:	zen of What Cou	ntry?
	th wi		1916 Stanhope	Road			21222			ted Stat	es
	hours after death with the Maryland lural; or Iteme 23e or 28e-1 ehow al Examinar must be notified at	Funeral	11. Marital Status	12. Was Decedent Ever Armed Forces?	in U.S. 1	<ol><li>Was Decedent of Hi If Yes, specify Cuba</li></ol>	spanic Origin? (S n, Mexican, Puert	pecify Yes or N o Rican, etc.)	0-	<ol> <li>Race - Ameri Black, White,</li> </ol>	
2	or It	y Fu	1 Never Married 25 Married	1XXYes 2 ☐ No If Yes, Give		1 ☐ Yes 2XXNo	Specify:			Specify:	National design
Š	ural	d by	3 Widowed 4 Divorced	Year or Dates:	16a Da	cedent's Usual Occupa	tion		165 Ki	nd of Business/Ir	White
9500-61212	n 72 l	Completed	15. Decedent's Ed (Specify only highest gra	de completed)	(G	ive kind of work done one. DO NOT use retired	turing most of wor	rking	100. KI	nd of Business/if	dustry
17	within 72 ene. than *nat	E G	Elementary/Secondary (0-12)  12 Years	College (1-4or 5+)		Brakeman	,			Railroa	d
	be filed within 72 hours after death with the Marylan lal Hyglene. d other than "natural", or Iteme 23s or 28s-1 show event. The Medical Examinar must be notified at		17. Father's Name (First, Middle, Last)		<u> </u>	DEGREEM	18. Mother's Nan	ne (First, Middle	, Maiden		
a	wild be f Mental H arked of	To Be	Anthony Pawlik	owski		-		France	s Sp	inek	
Maryland		۲	19a. Informant's Name/Relationship (		19b. Ma	ailing Address (Street a	and Number or Ru	ıral Route Numi	er, City o	r Town, State, Zij	o Code)
	ith all	l ji	Mrs. Elizabeth J.	Pawlikowski	19	016 Stanhop	e Road	Dunda1k	, Ma:	ryland	21222
ē,	is 1 and 2 sho of Health and . Item 27 is ma other trauma		20a. Method of Disposition	1	b. Place of Dis	sposition (Name of crematory or other place	ا	Date	20c. Lo	cation - City or T	own, State
Baltimore,	permit. Pages Department of I Importent: if Ite any Injury or of once.		1 Burial 2 Cremation 3  4 Donation 5 Trother (Specification)			ens of Fait		10/31/20	06	Baltimo	ore, MD
	orter	- 1	21. Sign were of Funeral Service Licer		,	22. Name and Address Duda-Ruck				Jalle Te	
ñ		5 9	110	. ( 2 !!	/	7922 Wise					
		9	23a. Part. Enter the disease, or com shock, or heart failure. List only	plications that caused the	death. Do not					2.17	Approximate Interval Between
	Physician		Immediate Cause (Final	a PWRU	LA N MIT	K				-	Onset and Death
	/Medical		disease or condition resulting in death)	a. Due to (or as a cor		т.					
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		Je.	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a cor	sequence of:						
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j J	en ar		resulting in death) Last	Due to (or as a cor	sequence of):						
8/60,	The law requires that the death certificate be executed site has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	dical		d							
9	ntifica ng ph s as ti	Ved	IF FEMALE:								
XOD	eath certific attending p I for use as	by Physician/Me	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pro	Fetal death	3 ☐Ectopic pregnancy			2	23d. Date of deliv Month	rery Day Year
	at the dea by the at rtached fo	Sici	1 Yes 2 No	4☐ Pregnant at time 9☐ Unknown	of death	5 Other (specify)				WOILLI	Day Tour
J.	d by etach	P.	Part II. Other significant conditions of	antibuting to death but no	regulting in th	o undorbina acuso su	on in Bort I	23a Did	tobacco u	se contribute to I	the cause of death?
	res tha		Part II. Other significant conditions of	onthouting to death but no	resulting in th	e underlying cause give	en in Part I.		Yes 2		
Hecords,	w require been sk should t	ted							163 20	1	
ec	law nasb	nple							psy	prior to co	opsy findings available ompletion of cause of
	: The law cete has I	Completed						1 ☐ Yes	ormed? 2/ No	death? 1 ☐ Yes	2 □ No
Vital	ysician: Th is certificete director, pag	Be	25. Was case referred to medical examiner?	Hospital:		Other	26. Place of Dea				
	Physical direction	2	1 Yes 2 No	1 Vinpatient	2 ER/Outpa		- Indiang i	lome 5 ☐ Res		6 ☐Other (Speci	fy)
<u></u>	ling F	on	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Yea	ar) 28b. Tim Inju	ry Worl	γat k? Yes 2∐No	280. Describe	now injur	y occurred	
<u>s</u>	death death tor:	icat	2 Accident investigation 3 Suicide 6 Could not b	9 29a Place of Injunt	At home farm		163 2 110	28f Location	(Street an	d Number or Bur	al Route Number,
Division of	or A efter Direction by	Certification;	4 ☐ Homicide determined	building, etc. (S)		, street, factory, office			wn, State		ar ricoto reginoer,
_	To the Hospitel or Attending Physicien: within 24 hours effer death. To the Funeral Director: Affer this certifical completely filled in by the funeral director.		29a. Certifier 1 Dentifying Pt	nysician: To the best of my	Resolutación est	wath occurrent at the rin	na idata and class	1 e end dua to the	Caus del	and manner as a	stated
	24 h 24 h Fun etely	Medical		niner: On the basis of examiner stated.							
	omple	₩ W	29b. Signature and title of certifier	, /2		29c. License	e number		29d. Dat	e signed (Month,	Day, Year)
	L∞ ≥ L∞ ()		Malia	R Telles		DE	5-000		OCTO	3EU 27	2006
	121	N.	30. Name and address of person who	completed cause of death	(Item 23a) (Tv		, , , , ,			- / L	
	ON,		DR. JUSTIA PRI			N AVENUE	BALTIM	ORE, M.	0. 2	1224	
	Sta	ite	31. Date filed (Month, Day, Year)	32. Registrar's S							
	Regist		NOV 0 1 7	2006	S.	Grande					
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiens, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician William J. Poland 9:17 A. M October 30 2006 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Glen Burnie Anne Arundel 303 Rainwater Way Unit 103 If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | March | 23,1937 Birthplace (State or Foreign Country)
 Maryland 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 12 M 2□ F 219 32 6189 69 Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits r then "natural", or iteme 23a or 28a-f eho the Medical Examinar must be notified at 1 ☐ Yes 2 No Director Maryland Anne Arundel Glen Burnie 10e. Street and Number 10g. Citizen of What Country? U.S. 303 Rainwater Way Unit 103 21060 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 17 Yes 2 No If Yes, Give Year or Dates 1956—1959 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White à 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)
Sales & Service 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Office Equipment 18. Mother's Name (First, Middle, Maiden Sumame)
Mary A. Stankiewicz 17. Father's Name (First, Middle, Last) Be William H. Poland P 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gina Hare / Daughter 4920 Preston Road Federalsburg, Maryland 21632 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages nent of t 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State artment ortant: I injury o Baltimore, Maryland 11/3/2006 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory 21. Signature of Funeral Licensia 22. Name and Address of Facility Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 xommous my the enter the mode of dying, such as cardiac or respiratory arrest, 23. Part1. Enter the disease, or complications that caused the death, shock, or heart failure. Little typine cause on each line. Immediate Cause (Final Small cell lung cancer **Physician** 3 months disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine The law requires that the death certificate be executed attending physicien and for use as the burial-trans resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 X Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has funeral director, page 2: autopsy performed? Yes 2 No 1 Yes 2 No 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 🛣 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No 28a. Date of Injury (Month, Day Year) Certification: 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 Pending 1 Yes 2 No investigation 2 Accident the 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital o within 24 hours aff To the Funeral DI 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check or one) 29b. Signature a 29c. License number 29d. Date signed (Month, Day, Year) D0055065 October 30, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Martin J. Edelman, M.D. Greenebaum Cancer Center, 22 S. greene St. N9E08, Baltimore, MD 21201 31. Date filed (Month Day Year) 1 2006 32. Aggistrar's Signature State Registrar

Physician /Medical Examiner  Anna Virginia Peusch  Ab. City, Town, or Location of Death  Baltimore  S. Social Security Number  217 12 3819  Anna Virginia Peusch  Ab. City, Town, or Location of Death  Baltimore  Oct. 19, 1924  Ac. County of Death  Baltimore  Oct. 19, 1924  Maryland  Usual Residence of Decedent  10a. State 10b. County  10b. City, Town or Location  10d. Inside City Lin		•	For State Registrar	e of Maryland / Dep Ce	partment of He ertificate of E	ealth and M Death		ene2 () (	16 3469
Statistics of Park Shospics of Statistics of Park Shospics of Statistics of Park Shospics of Statistics of Park Shospics of Statistics of Park Shospics of Park				a Virginia Peu	sch		Month	<sup>Day</sup> 20	3. Time of Death 906 5:40 A.
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The State of Designation of Country and Part o			217 12 3819 ¹□M 2₫				8. Date of Birth (Month, Day, Y) Oct. 19,	1924	9. Birthplace (State or Fore Country) Maryland
17. Father's Name (First, Middle, Last) Joseph E. Mick   10s. Mother's Name (First, Middle, Last) Joseph E. Mick   10s. Mother's Name (First, Middle, Last) Joseph E. Mick   10s. Mother's Name (First, Middle, Last) Joseph E. Mick   10s. Mother's Name (First, Middle, Last) Joseph E. Mick   10s. Mother's Name (First, Middle, Last) Joseph E. Mick   10s. Mother's Name (First, Middle, Last) Joseph E. Mick   10s. Mother's Name (First, Middle, Last) Joseph E. Mick   10s. Mother's Name (First, Middle, Last) Joseph E. Mick   10s. Mother's Name (First, Middle, Last) Joseph E. Mick   10s. Mother's Name (First, Middle, Last) Joseph E. Mick   10s. Mother's Name (First, Middle, Last) Joseph E. Mick   10s. Mother's Name (First, Middle, Last) Joseph E. Mick   10s. Mother's Name (First, Middle, Last) Joseph E. Mick   10s. Mother's Name (First, Middle, Last) Joseph E. Mick   10s. Mother's Name (First, Middle, Last) Joseph E. Mick   10s. Mother's Name (First, Middle, Last) Joseph E. Mick   10s. Mother's Name (First, Middle, Last) Joseph E. Mick   10s. Mother's Name (First, Middle, Last) Joseph E. Mick   10s. Mother's Name (First, Middle, Middle, Last) Joseph E. Mick   10s. Mother's Name (First, Middle, Mi	Maryland L-f ehow	Ī	10a. State 10b. County					· · · · <u>-</u>	10d. Inside City Lim 1 ☐ Yes 2 🛣
17. Father's Name (First, Middle, Last)	with the	Direc		Road		25	10g		nat Country?
17. Father's Name (First, Middle, Last)   19. Mailing Assires (Street and Number or Rural Route Number, City or Town, State, 25 Code)   19. Mailing Assires (Street and Number or Rural Route Number, City or Town, State, 25 Code)   19. Mailing Assires (Street and Number or Rural Route Number, City or Town, State, 25 Code)   19. Mailing Assires (Street and Number or Rural Route Number, City or Town, State, 25 Code)   19. Mailing Assires (Street and Number or Rural Route Number, City or Town, State, 25 Code)   19. Mailing Assires (Street and Number or Rural Route Number, City or Town, State, 25 Code)   19. Mailing Assires (Street and Number or Rural Route Number, City or Town, State, 26 Code)   19. Mailing Assires (Street and Number or Rural Route Number, City or Town, State, 27 Code)   19. Mailing Assires (Street and Number or Rural Route Number, City or Town, State, 27 Code)   19. Mailing Assires (Street and Number or Rural Route Number, City or Town, State, 27 Code)   19. Mailing Assires (Street and Number or Rural Route Number, City or Town, State, 27 Code)   19. Mailing Assires (Street and Number or Rural Route Number, City or Town, State, 28 Code)   19. Mailing Assires (Street and Number or Rural Route Number, City or Town, State, 29 Code)   19. Mailing Assires (Street and Number or Rural Route Number, City or Town, State, 29 Code)   19. Mailing Assires (Street and Number or Rural Route Number, City or Town, State, 20 Code)   19. Mailing Assires (Street and Number or Rural Route Number, City or Town, State, 20 Code)   19. Mailing Assires (Street and Number or Rural Route Number, City or Town, State, 20 Code)   19. Mailing Assires (Street and Number or Rural Route Number, City or Town, State, 20 Code)   19. Mailing Assires (Street and Number or Rural Route Number, City or Town, State, 20 Code)   19. Mailing Assires (Street and Number or Rural Route Number, City or Town, State, 20 Code)   19. Mailing Assires (Street and Number or Rural Route Number, City or Town, State, 20 Code)   19. Mailing Assires (Street	urs after deeth at', or items 2: Exeminer in ut	by Funera	11. Marital Status  1 Never Married 2 Americal 1 Never Married 2 Never Married 2 Never Married 1 Never Married	Decedent Ever in U.S. 13 ed Forces? Yes 2 1 No s. Give	B. Was Decedent of His If Yes, specify Cubar	spanic Origin? (Spe n, Mexican, Puerto	ocfly Yes or No- Rican, etc.)	14. Race Black	, White, etc.
17. Pather's Name (Pirat, Modele, Aside Summan)   18. Moder's Name (Pirat, Modele, Asidem Summan)   19. Mailing Address (Streat and Number or Rural Route Name(Pirat, Modele, Asidem Summan)   19. Mailing Address (Streat and Number or Rural Route Number, City or Town, State, Zp Code)   27. 12. Appleased Road   Finksburg, Maryland 21048   27. Appleased Road   Finksburg, M	d within 72 ho giene. or than "natur the Medical	ompleted	(Specify only highest grade comple	ree (1-4or 5+)	ve kind of work done di . DO NOT use retired)	ition uring most of worki	ng 16		•
Same and Address of Facility   Commonwealth   Com	Mental Hyg Mental Hyg arkad othe atic avent,	e n		Mick					)
1. Starting of Suppose   1. Starting of Supp	nd 2 sho lith and 1 27 is ma r trauma								
23a   fact   Stadem disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, index of cause fallure. List only one cause on each line.    Approximate Inflered Between Cheef and Death   Immediate Cause (fallure). List only one cause on each line.    Approximate Inflered Between Cheef and Death   Immediate Cause (fileses or plury that initiated events resulting in death). Last   Due to (or as a consequence of):	ages 1 and of Head it if item	1	1 XBurial 2 ☐ Cremation 3 ☐ Removal	from State cemetery, cr	ematory or other place	9)			•
23a. I hr.1. Shazahr disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, inflexed selections, continuous cause on each line.    Approximate Inflexed Selection (Present and David Cheer an	permit. Pa Departmen Important any injury once.		A		22. Name and Address	s of Facility Go	nce Funei	ral Ser	vice. P.A.
Due to (or as a consequence of):    Due to (or as a consequence of):   Due to (or as a consequence of to (or as a consequence of):   Due to (or as a consequ	/Medical Examiner	iner	shock, or heart failure. List only one cause Immediate Cause (Final disease or condition resulting in death)	on each line.  NG CANCER e to (or as a consequence of):	nter the mode of dying	), such as cardiac o	r respiratory arrest	t,	Interval Between
in the past 12 months?   1   ves 2   No 3   Probably 4     Unknown    Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.    1   ves 2   No 3   Probably 4     Unknown    Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.    1   ves 2   No 3   Probably 4     Unknown    24a. Was an autopsy parformed?   1   ves 2   No    25. Was case referred to medical examiner?    1   ves 2   No    26. Place of Death   Check only one    27. Manner of Death   1   Norsing Home   5   Residence   1   Ves 2   No    28. Date of lingury at work?    1   ves 2   No    28. Date of lingury at work?    1   ves 2   No    28. Date of lingury at work?    1   ves 2   No    29. Date of lingury at home   28c. Injury at work?    29. Date of lingury at home   28c. Injury at work?    29. Date of lingury at home   28c. Injury at work?    29. Date of lingury at home   28c. Injury at work?    29. Date of lingury at home, farm, street, factory, office    28. Location (Street and Number or Rural Route Number, City or Town, State)    29. Date of lingury at home, date and place, and due to the cause(s) and manner as stated.    29. Date of lingury at home, date and place, and due to the cause(s) and manner as stated.    29. Signature and (title of certifier)    29. Signature and (title of certifier)    29. Date signed (Month, Day, Year)	ohysicie the bur	dical Exa	resulting in death) Last C. Du					1	
1   Yes 2   No 3   Probably 4	= - 6	nysician	in the past 12 months?	ive birth 2 Fetal death 3 Pregnant at time of death 5					
25. Was case referred to medical examiner?  1	eduires that an signed to and be det	ed by r	Part II. Other significant conditions contributing	to death but not resulting in the	underlying cause give	n in Part I.		_	
The state of the	0 0 0		25. Was case referred to medical			OS Place of Death	autopsy performe	a? ae	atn?
29a. Certifier  (Check only one)  29a. Certifier  (Check only one)  29b. Signature and little of certifier  29c. License number  29d. Date signed (Month, Day, Year)	this all dia	2	1 ☐ Yes 2 📆 No Hospital:  27. Manner of Death 1 📆 Natural 5 ☐ Pending		of 28c. Injury Work	at 2	ne 5□Residend		
29a. Certifier  (Check only one)  29a. Certifier  (Check only one)  29b. Signature and little of certifier  29c. License number  29d. Date signed (Month, Day, Year)	al or Attend s after death il Director: , id in by the f	erincat	2 Accident Investigation 3 Suicide 6 Could not be determined 28e. F	Place of Injury - At home, farm, souilding, etc. (Specify)			28f. Location (Stree City or Town, S	et and Number State)	or Rural Route Number,
	n 24 hour ne Funera pletely fille		(Check only 2 Medical Examiner: On t	he basis of examination and/or i	ath occurred at the time investigation, in my opi	e, date and place, a inion, death occurre	and due to the caused at the time, date	se(s) and mani and place, an	ner as stated. d due to the cause(s)
	To the To the Comp	Σ	29b. Signature and (title of certifier				29d.		1 1

OCTOBER 29, 2006 5:40 a.m.

ANNA PEUSCH

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Marvland / Department of Health and Mental Hygiene O O C

			1 - For State Registrar	State of W	C	epartment of Certificate of			giene 006 Reg. No.	34695
	Physic	ian	1. Decedent's Name (First, Midd					2. Date of Dea Month		3. Time of Death
	/Medi	cal	GLENN		ATTERS			OCT	19 2006	6 11.00AM
	Examir	ner	4a. Facility Name (If not institution Howard County				or Location of Death	h	4c. County of D	
F	uneral		5. Social Security Number		pital ge (In yrs. last birthd	ay) If Under 1 Yea				vard Birthplace (State or Foreign
	irector		230-12-6967	1 <b>∑</b> M 2□F	82 Yrs	Months Days	Hours Min.	Feb 24		Birthplace (State or Foreign Country) irginia
and	A 11		Usual Residence of Decedent  10a. State 10b. County	,	10c. City, Town or	r Location				10d. Inside City Limits
Mary	유급	ţō	MD Hov	ward	Co1	Lumbia				1 ☐ Yes 2√ No
th the	or 28g	)lrec	10e. Street and Number			10f. Zip Code			10g. Citizen of What	Country?
ath w	23a	rai	6334 Cedar Lar	ne		210			USA	
5-0036 72 hours after death with the Maryland	of other than "natural", or liems 23a or 28a-f show event, I're Miclical Examiner must be notified at	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Mai 3 □ Widowed 4 □ □ Divorced	If Yes Give	Ever in U.S. 1	<ol> <li>Was Decedent of If Yes, specify Cul</li> <li>1 ☐ Yes 2 X No</li> </ol>		pecify Yes or No- o Rican, etc.)	14. Race - Ai Black, W Specify: W	
2-6 72 hc	natu	Be Completed	15. Deceder (Specify only highe	nt's Education est grade completed)	16a. De	cedent's Usual Occu ive kind of work done b. DO NOT use retin	ipation	kina	16b. Kind of Busine:	ss/Industry
LZTZ D	than	mpi	Elementary/Secondary (0-12) unk	College (1-4or	5+)		ed)			
D E	ent,	C	17. Father's Name (First, Middle,	unk Last)	C	arpenter unk	18. Mother's Nam		home impro	ovements unk
Maryland d 2 should be file	, J 0	To B								
Taryia	7 is mari traumati	i i	19a. Informant's Name/Relations			ailing Address (Stree	t and Number or Ru	ral Route Numbe	r, City or Town, State	a, Zip Code)
_ <u> </u>	item 27 other to		Howard County 20a. Method of Disposition	General Hosp		55 Cedar :				
timore,			1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☒ Other (5	3 □Removal from State	cemetery, c	rematory or other pla	ace)	Date	20c. Location - City	or Town, State
	Important: If any injury o	li	21. Signature of Fineral Service			22. Name and Addr	ess of Facility	1 (55 ***	Baltimor	
	E = 8		Hom	6/1014	le ?	Baltimore	MD 212	0.1		e Street
			23a. Part1. Enter the disease, or shock, or heart failure. List	r complications that caused only one cause on each li	the death. Do not e	enter the mode of dy	ing, such as cardiac	or respiratory arr	est,	Approximate Interval Between
	sician ledical		Immediate Cause (Final disease or condition resulting in death)	a. END	STA G	E DEN	IENTIA			Monetand Death
	miner		,		a consequence of):		<b>~</b>	-		of an install
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as	a consequence of):	2 70	IMICIO	E		cay)
ecuted	transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last		CVD					year
o/ou, ate be ex	ician a	at Ex	resonting in death) Last	d. Rer	a consequence of):	ALUN	-			
00 / ficate	ig physician and as the burial-transit	Medical		d. 1161	IAC I	HIL USD				moneto
OI VILLA I DECOLUS, F.O. BOX 66/60, Physician: The law requires that the death certificate be executed	attendir for use	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death 3	3 ⊟Ectopic pregnand 5 □ Other (specify) _	у		23d. Date of d Month	lelivery Day Year
y, ⊓ 9sthal	gned I	by Pi	Part II. Other significant condition	ons contributing to death b	ut not resulting in the	underlying cause gr	ven in Part I.	23e. Did tob	pacco use contribute	to the cause of death?
v requires	pinou							1 □ Y€	s 2 No 3 1	Probably 4 Unknown
The law	After this certificete has been signed by the i funeral director, page 2 should be detached	Completed						24a. Was a autops perform	neg death?	autopsy findings available completion of cause of 2
Siciar	recto	o Be	25. Was case referred to medica examiner?	Hospital:		Ot	26. Place of Deat	7		
2 g	er this	n: To	27. Manner of Death	1 Inpatie	ry 28b. Time	of 28c. Inju	4 🗆 Nursing Ho		ence 6 Other (Sp	pecify)
ath.	or: Aft he fun	atio	t ☑Natural 5 ☐ Pendin 2 ☐ Accident investig	gation	<i>Year)</i> Injury		rk? ]Yes 2 □ No			
or Att	Direct in by t	Certification:	3 Suicide 6 Could a determination		ury - At home, farm, s c. (Specify)	street, factory, office		28f. Location (St. City or Town	reet and Number or F n, State)	Rural Route Number,
lospital	To the Funeral Director: After ti completely filled in by the funera		29a. Certifier Certifyin	ng Physician: To the best of Examiner: On the basis of	of my knowledge, de	ath occurred at the ti	me, date and place,	and due to the ca	iuse(s) and manner a	as stated.
thin 2	the l	Medicai	one) 29b. Signature and title of certifie	and mailler sta	ited.	29c. Licens				
¥ ×	F 8		Smore	MD		DOC	25311°		9d. Date signed (Mor	an, Day, Tear)
			30. Name and address of person	who completed cause of d	eath (Item 23a) (Type	e, Print)				000
			Shellnn	iale su	ple 9	650 50	entiap	o Rec	2d, C	2006 Le 110 Diumbie
· ·	Sta Registra		31. Date filed (Month, Day, Year)	32. Registra	ar's Signature	sell !				21045

State of Maryland / Department of Health and Mental Hygiene, For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** Ам 2:41 Ellen 31 2006 Redford October Frances /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner N/A 1114 Haverhill Road Baltimore 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🕅 F 218-28-9521 Maryland 1932 Director 74 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b County ir than "natural", or itema 23e or 28e-f ahow The Medical Examiner must be notified at 1 Yes 2 □ No N/A Directo Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1114 Haverhill Road 21229 USA 1 and 2 should be filed within 72 hours after death. Heelth and Mental Hygiene. Iam 27 Ia marked other than "natural", or tema 23, ther traumatic event, I'ra Medical Examinar must Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 20 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2X No ð 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) William T. Burnett Clerical Accounting 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be James Carter Balderson Margaret Adelaide Frey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 a Department of Heelith ar Important: If itam 27 ta any injury or other trau Willis Redford, Jr. (Husband) 1114 Haverhill Rd., Baltimore, Maryland 21229 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Bayview Crematory, Inc. 11/3/2006 4 □ Donation 5 □ Other (Specify) Baltimore, Maryland 21. Signature of Fuvieral Service Licensee Kevin E Ecker

22. Name and Address of Facility

McCully-Polyniak Funeral Home, P.

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Immediate Cause / Final Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** METASTATIC COLON month disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). Examiner The law requires that the death certificate be executed attending physicien and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 XNo
9 Unknown 4☐Pregnant at time of death 5 Other (specify) signed by the a Id be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by should t 1 🗌 Yes 25 No 3 Probably 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No 24a. Was an page 2 s autopsy certificate 1 ☐ Yes To the Hospitel or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Hospital: Other: 4 Nursing Home 25 No ٩ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 □Other (Specify) this eral Director: After thi 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Alatural 2 Accident 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours e Testifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifiei Medical and manner stated 29b. Signature and the of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) E.W. COLE ST AGNES 900 CATON AVE BALTIMORE MD 21229 31. Date filed (Month, Day, Year) 32 Registrar's Signature State NOV 0 1 2006 Registrar

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] [] [5] 1 - For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Worth 26, 2006 **Physician** 7:05 A Patricia Ann Reinhart /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Calvert <u>Calvert Memorial Hospital</u> Prince Frederick If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** XX□M 2□F Months Days Hours 579 50 5033 Yrs. Director 1937 Washington DC Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan ment of Health and Mental Hyglene.
ant: if Item 27 is marked other than "natural", or items 23e or 28e-f ehow ury or other than "in Medical Examination in the instance or page 1 and 1 10d. Inside City Limits 1 □ Yes 2 □ No Director Maryland Calvert Solomons Island 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1103 Backcreek Loop United States by Funeral 20688 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ Yo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1□Yes 🏚 No Specify 3 ☐ Widowed 4 ☑ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 4t Precurement Specialist Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Alma Schafer Phillip Theunissen 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Raymond Reinhart (son) 13511 Arrowwood Lane, Bowie, MD 20715 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State t Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important; if eny Injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Cedar Hill Cemetery Oct 28, 2006 Suitland, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Lee Funeral Home, Inc 663301d MOIZ84 Alexandria Ferry Road, Clinton, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** metastatic disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner inding physicien and use as the burial-transit or Attending Physicien: The law requires that the death certificate be executed P.O. Box 68760% Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death in the past 12 months? 3 Ectopic pregnancy õ Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð Division of Vital Records. pege 2 should be 3 Probably 4 Unknown Be Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 1 Yes 2 No After this certification, funeral director, 25. Was case referred to medical 26. Place of Death | Check only one Hospital: Annatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending within 24 hours after death.

To the Funerel Director; A completely filled in by the fu investigation 1 Tes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only onel the e 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0060475 10/26/06

8

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

100 HOSPITAL

10V 0 1 2000

BUSH

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

ORIGINAL

ROAD, PRINCE PREDERICK

			4 101	Department of Health and Mental Hygie  Certificate of Death	2000 34050
	Physici	an	1. Decedent's Name (First, Middle, Last)  SLADYS	DOCE 2. Date of Death Month	Day Year 3. Time ol Death
)	/Medic Examir		4a. Facility Name (If not institution, give street and number)  SECOLR † 1054  5. Social Security Number   6. Sex   7. Age (In yrs. last bird	2. 4b. City, Fawn, or Location of Death Daltinore	4c. County of Death  9. Birthplace (State or Foreign
	Funeral Director		COC DIE	Yrs. Months Days Hours Min. (Month, Day, Yes. Pug: 16,1	ar) Country /
	e Marylan Sa-f ehow	ctor	10a. State 10b. County 10c. City, Town	Baltimore	10d. Inside City Limits 1 Yes 2 □ No
	ath with th	Funeral Director	10e. Street and Number 2209 Booth St.	2/223	Citizen of What Country?
036	within 72 hours after death with the Maryland ene. then "naturet", or items 23e or 28e-f ehow he Madigal Examiner must be natified at	þ	11. Marital Status  1 □ Never Married 2 □ Married  3 ▼Wildowed 4 □ Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Yes 2 ○ ○ ○ ○ ○ ○ ○ ○ ○ ○ ○ ○ ○ ○ ○ ○ ○ ○	Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)     □ Yes 2 No Specify:	14. Race - American Indian, Black, White, etc. Specify:
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Depertment of Health and Mental Hygiene. Important: if item 27 is marked other then "naturel", or items 23s or 28s-f show appriantly or other traumatic event, the Madical Examiner must be nullised at ODGe.	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)	(Give kind of work done during most of working life DO NOT use retired)	Control of Business/Industry
Maryland	iould be filed I Mental Hygi barked other batic event, t	To Be (	17. Father's Name (First, Middle, Last)  James F. Lovick	18. Mother's Name (First, Middle, Mai	den Sumame) DWAT
-	l end 2 sh lealth and im 27 ie m iher traum		Harry RoseJR Son 20		md. 21223
Baltimore	it. Pages intent of the reant: if ite		1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	y, crematory or other place) $11/3/2006$	Location - City or Town, State  ausdown md.
Ba	permit. Depertrimports imports eny inte		Yel had		ne 5alp ind, 21229
) .	Physician hysician and physician and physician and physician and the pruial-transit	Examiner	23a. Part I chief the disease, or complications that caused the death. Do not shook, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of Due to (or as	wixtant Enterococcus Lepl	Approximate Interval Between Onset and Death
P.O. Box 68760,	Attending Physician: The law requires that the death certificate be executed in death.  clor: After this certificate has been signed by the ettending physicien and by the funeral director, page 2 should be deteched for use as the burial-transit.	Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown   Unknow	3   Ectopic pregnancy 5   Other (specify)	23d. Date of delivery Month Day Year
rds, P.	quires that the signed by and be detacted.	d by Ph	Part II. Other significant conditions contributing to death but not resulting in	the underlying cause given in Part I. 23e. Did tobact	couse contribute to the cause of death?  2 No 3 Probably 4 Maunown
Division of Vital Records,	The law rec cete has bee page 2 shou	Complete	Dialetes mellitus Type &	24a. Was an autopsy performed 1 □ Yes 2 2 ☑	
fVita	lysician lis certifi director	To Be	25. Was case referred to medical examiner?  1 Yes 2 X No  Hospital: 1 Impatient 2 ER/Out	26. Place of Death Check only one tpatient 3 DOA Cther: 4 Nursing Home 5 Residence	6 □Other (Specify)
o uo	nding Pt th. : After the funeral	tlon:	27. Manner of Death  1 Manual 5 Pending (Month, Day Year)  2 Accident investigation		
DIVIS	To the Hoepital or Attending Physician: The lawithin 24 hours after death.  To the Funeral Director After this certificete has completely filled in by the funeral director, page 2	Certification;	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place ol Injury - At home, far building, etc. (Specify)	rm, street, factory, office  28I. Location (Stree City or Town, S.	and Number or Rural Route Number, ate)
	To the Hoepital or A within 24 hours after To the Funeral Directompletely filled in by	edical	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, 2 Medical Examiner: On the basis of examination and and manner stated.	, death occurred at the time, date and place, and due to the cause d/or investigation, in my opinion, death occurred at the time, date	e(s) and manner as stated. and place, and due to the cause(s)
)		Σ	29b. Signature and title of certifier PHYSICIAN		Date signed (Month, Day, Year)
	3		30. Name and address of person who completed cause of death (Item 23a) ( P. SANDHU, MP. 1940 W.	Type, Print) BALTIMORE ST, BALTI	10-28-06 more, mD21223
	Sta	te	31. Date liled (Monty Pay Year) 1 2006 32. Begistrar's Signature	Specie	

State of Maryland / Department of Health and Mental Hygien 005 For State Registra Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month Year 6 **Physician** 2-76 10 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner NA Hos MU mp 11 unc 0 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last/birthday) If Under 1 Year If Under 24 Hrs. 6. Sex Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Days Hours Min 1 ☐ M 2 🕏 F 67 Director 216-36-6269 2-11-39 Md Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 7 is marked other then "naturel", or Items 23a or 28a-f show traumatic event, the Medical Exandrar must be notified at 10a. State 10b. County 1 Yes 2 No Director Baltimore Md. NA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? With USA 21218 1762 Gorsuch Avenue ges 1 and 2 should be filed within 72 hours after death is tof Health and Mental Hygiene. If flem 27 is marked other then "naturel", or flems 236 Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give A Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: Black 2 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 8th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be McDuffie Ethel Price Alfred 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21218 1762 Gorsuch Avenue, Baltimore, Md. Husband Earl Robinson 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Important: If Ite any Injury or otl ance. 1 Burial 2 Cremation 3 Removal from State 11-1-06 Dundalk, Md. Mt. Carmel Cem. 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F.H. East 21202 2 a 1101 E. North Avenue, Baltimore, Md. W ane 8 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner 0 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed ed by the attending physicien and detached for use as the burial-transit Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If ves, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy in the past 12 months? Month Dav 4☐Pregnant at time of death 5 Other (specify) ☐ Yes 2 ☑ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? 5 1 Yes 2 No 1 Yes 2 1 NO To the Hospital or Attending Physician: 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 No ၉ 1 Impatient 2 ER/Outpatient 3 DOA 1 Tes After this 28b. Time of Injury 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 PNatural 5 Pending after death. Director: A 1 Tes 2 🗌 No investigation 2 Accident the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours To the Funeral 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2/2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3 5601 00 16 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registra

			1 - For State Registrar	State of Ma	ryland / D	epartme <i>Certifica</i>	ent of He ate of D	ealth and N Death		gien <b>g</b> Reg. No.	J06	34700
ı	Physici	an	1. Decedent's Name (First, Middle, Las	rt)	-				2. Date of De	ath BE <b>R</b> ay E	9,200	3. Time of Death
	/Medic Examin	al	ANN V. RIEGGER  4a. Facility Name (# not institution, pick	street and number)	Cente	4b. Ci	ty, Town, or L	ocation of Death				timore
ı	Funeral		Social Security Number 6. S	ex 7. Age	(In yrs. last birti	hday) If Und	der 1 Year	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da Aug. 1			place (State or Foreign
	Director		214-30-4527 Usual Residence of Decedent	□ M 2 X F 7.	7 Y	rs.	54,0		Aug. 1	3,1929	9 Mai	ryland
	iryland show		10a. State 10b. County		10c. City, Town	or Location						10d. Inside City Limits
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	h with	ai Dir	4715 Hellwig Rd.			101.		21206		US		,
020	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If time 77 is marked other then "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be notified at once.	by Funeral Director	11. Marital Status  1 Never Married A Married  3 Widowed 4 Divorced	12. Was Decedent Ex Armed Forces? 1 ☐ Yes ※ No If Yes, Give Year or Dates:				panic Origin? (Sp , Mexican, Puerto Specify:	pecify Yes or No Rican, etc.)		Race - Ameri Black, White pecify: Wh	
2-003c	72 ho	eted	15. Decedent's Ec (Specify only highest gra	ucation de completed)	16a. I	Decedent's U (Give kind of	sual Occupat work done du	ion ring most of work	ing		of Business/Ir	•
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aua	al Hyg al Other	BeC	17. Father's Name (First, Middle, Last)	•			1	18. Mother's Nam	e (First, Middle,	Maiden Su	mame)	
Z Z	hould t d Ment marke matic	2	Franklin VanPelt 19a. Informant's Name/Relationship	Type Print)	19h	Mailing Addre	es (Streat an	Mary M	. Mixte		own State Zi	n Code)
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ore,	jes 1 a of Hei if item or oths		20a. Method of Disposition  1) Heurial 2 Cremation 3		20b. Place of cemetery	Disposition (A	lame of r other place)	1	Date	20c. Locat	ion - City or T	own, State
Saltimol	it. Pag intment intant: injury o		4 ☐ Donation 5 ☐ Other (Specify 21.	)	Woodlaw		etery and Address		-2006			Maryland
D D	Depa impo any i		Mother B	89chn		Lass	ahn Fu	neral H	ome		Belair o., Md.	21236
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X 0	- O #	/Med	IF FEMALE:	23c. If yes, outcome of	pregnancy					224	. Date of deliv	00/
	The law requires that the death certif ate has been signed by the attending page 2 should be detached for use a	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	1 ☐ Live birth 2 4 ☐ Pregnant at ti 9 ☐ Unknown	Fetal death	3 ☐ Ectopic 5 ☐ Other				230	Month	Day Year
ords,	uires that signed b	þ	Part II. Other significant conditions of BILLIARY OBSTRUC		not resulting in	the underlying	g cause given	in Part I.		obacco use		he cause of death?
בֿ ב	S 5 5	Completed	ARTERIAL THROMBO	SIS					24a. Was		4b. Were auto	opsy findings available impletion of cause of
	cate h	Com	ACUTE RENAL FAIL	URE						rmed?	death? 1 ☐ Yes	
2	s certif	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No	Hospital:	t 2 ER/Outs	natient 3		26. Place of Deat 4 ☐ Nursing Ho			Other (Speci	6v)
5	nding Phy th. : After this e funeral c	$\vdash$	27. Manner of Death  1 Statural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day	28b. Ti		28c. Injury a Work?		28d. Describe h			<b>y</b> )
	ai or Atte s efter de: oi Directo ed in by th	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injur building, etc.	y - At home, fam (Specify)	m, street, fact	ory, office		28f. Location (S City or Tou	Street and N vn, State)	umber or Run	al Route Number,
	To the Hospital or Attending Physicien: The within 24 hours efter death. To the Funerel Director: After this certificate ha completely filled in by the funeral director, page	edicai	29a. Certifier (Check only one) 2 Medical Exam	iner: On the bast of and manner state	xamination and	deeth croum /or investigati	ed at the time on, in my opir	date and place nion, death occur	and due to the red at the time,	date and pla	d manner as a ice, and due t	totad o the cause(s)
	To the within To the Comp	Σ	29b. Signature and title of certifier			2	9c. License r	number 7254		1	gned (Month,	
		i	30. Name and address of person who a	completed cause of des	ath (Item 23a) (1	[vpe, Print)	, ·			101	3010	<u>_</u>
1.	2		BOON POH LIM,	M.D. 7	601 OS		RIVE	TOWSO	N, MARYI	LAND	21204	
	Sta Registr		31. Date filed (Month Pay Year) 1 2	006 32. Registrar	's Signature	Speck	9 8					

Secretary Superior County Or Season   Secretary Superior County Or S	nysici	an		me (First, Middle, La	st)					Death	2. Date of De. Month Octobe	Day	2006	3 4 7 0 1 3. Time of Death 5:35 AM <sub>M</sub>	
5. Social Security Number  1. Social Security Nu	Medic	al .			re street and nu	mber)		4b. City	, Town, or	r Location of Deat					
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10.5 State   Not County   10.5 State   10.5 County   10.5 State   10			109-38-	8204			_					1953	9. Birthp	place (State or Foreign htry)	
23a. Part   Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, memorial cause. [Final resulting in death)   Part   Property and the past 12 months?	¥			7		10c. C	ity, Town or Lo	ocation					1	0d. Inside City Limits	
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23a. Part I. Enier the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line.    Immediate Cause Final			1 🗆 Burial	2 Cremation 3		State	cemetery, crei	matory or	other plac				-		
Immediate Cause (Final disease)   The Cause (Final disea	ony inju					2 mo135	8 22			ss of Facility Cres Ave. Silv	mation Se ver Sprin	rvices g, Mar	yland 2	0910-	
24a. Was an autopsy findings available prior to completion of cause of death?  25. Was case referred to medical examiner?  1   Yes   2   No    26. Place of Death (Check only one)  27. Manner of Death	nerial-transit		Immediate Caus disease or condi- resulting in death Sequentially list cause. Enter Un Cause (Disease that initiated ever	e (Final tition 1)  conditions, anni-oligite derlying or injury tits	a. Bue to b. Due to c. Due to	(or as a conse	Quence of):							Onset and Death	
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D 45880 16-30-06	funeral dir	tlon; To	27. Manner of De	ath 5 Pending	28a. Date (Mon		28b. Time o		28c. Injun Worl	y at k?				y)	
D 45880 16-30-06	d in by the	ertifica	3 🗍 Suicide	6 ☐ Could not b	28e, Place	of Injury - At I	nome, larm, str ify)				28f. Location (3 City or Tov	Street and Nu vn, State)	umber or Rura	al Route Number,	
D 45880 16-30-06	Stelly Illier		(Check only		miner: On the b	asis of examin									
		Me	29b. Signature	nd title of certifier	. (							29d. Date sig	gned (Month,	Day, Year)	
30. Name and add/ as of person who completed cause of death (Item 23a) (Type, Print)	duo		k 24							-					

Please Type or Printin Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death  $Q_{6}$ Gertrude Calderon Rondon Month 3/ **Physician** 0 0437 M /Medical County of Death 4b. City, Town, or Location of Death Facility Name (If not institution, give street and number)
Mariner Health of Greater Laurel Examiner Prince George's Laurel If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months | Months 9. Birthplace (State or Foreign Puerty Rico Social Security Number 093-28-1891 6. Sex 7. Age (Ingre. last birthday) **Funeral** 1 M 2 F Yrs Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 12 should be filed within rz income.
In end Mental Hygiene.
It's marked other than "natural", or items 23a or 28a-f ahow
It's marked other than "natural", or items 23a or 28a-f ahow MD Howard Columbia 1 Yes 2 No Director 10f. Zip Code 21046 10g. Citizen of What Country? USA 10e. Street and Number 9359 Guilford Road 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1⊠Yes 2□No SpecifyPuertoRican Specify: Hispanic Maryland 21215-0036 à 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Seamstress 65 Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last)
Muvechico Calderon 18. Mother's Name (First, Middle, Maiden Surname)
Filomena Correa Be ဥ 19b Mailing Address (Street and Number or Rural Boute Number City or Town, State, Zip Code) P.O. Box 121 Savage, MD 20763 19a Informant's Name/Relationship (Type, Print) of Health of Hem 27 is Baltimore, 20b. Place of Disposition (Name of 20a. Method of Disposition Davov 1 20c. Location - City or Town, State Chesapeake Crematory Inc. 2006 1 ☐ Burial 2 ØCremation 3 ☐ Removal from State Beltsville, Maryland ö permit. Page Department of Important: if any Injury or once. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22OremationsandacHuneral Alternatives 8717 Green Pastures Drive Baltimore, Maryland 21286 Sue Rether Moly Approximate Interval Between Onset and Death 23a. Part1. Effer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** 4/monary /Medical Due to (or as a consequence of): **Examiner** sease inlar Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine ettending physician and for use as the burial-transit The law requires that the daath certificate be executed leura 0 resulting in death) Last Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 mooths? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. been signed by the should be detached 9 Unknown 9 Unknown Part II. Wher significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has t irector, page 2 s perform 1 Yes 1☐ Yes of Vital funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No this To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medicai Certification: Division Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death consmod at the time, date and place, and due to the nause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mainner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ed cause of death (Item 23a) (Type, Print) 3 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 2006

			For State of Maryland	•	tificate of		vientai H	ygier Reg. 1	2006	34703					
<b>8</b>	Physicia	an	Decedent's Name (First, Middle, Last)				2. Date of I	E	Day Yea						
	/Medic	al	Ellis Van Reeves 4a. Facility Name (If not institution, give street and number)		4h City Town o	r Location of Death	octob		26, 200 4c. County of De						
	Examin	er	Union Memorial Hospital		Baltim										
3	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. la.	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of l	Birth Day, Yea	9. B	irthplace (State or Foreign Country)					
ši	Director		212-03-1341	115.			Mar.	11,	1918 No	rth Carolina					
	yland now at			Town or Loc	cation					10d. Inside City Limits					
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	with the a or 2 the no		10e. Street and Number		10f. Zip Code			10g. (	Citizen of What (	country ?					
	death ms 23	Funeral	451-4 Moores Mill Rd.  11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?	. 13. V	Vas Decedent of H	4 lispanic Origin? (S an, Mexican, Puert	pecify Yes or I	No-	USA 14. Race - An Black, Wh						
õ	within 72 hours after death with the Maryland ene. than "natural", or Items 23a or 28a-f show hs Medical Examiner must be notified at		1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🛣 No If Yes, Give		☐ Yes 2√2 No	Specify:	o moun, etc.)		Specify:	me, etc.					
12-0036	hours ttural"	ed by	3X Widowed 4 □ Divorced Year or Dates:  15. Decedent's Education	16a. Deced	ent's Usual Occup	pation		16b.	Kind of Busines	hite s/Industry					
<u>7</u>	hin 72 e. an "na Medic	Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)	(Give I life. E	kind of work done OO NOT use retired	during most of word)	rking								
7	ygi f, t		11 17. Father's Name (First, Middle, Last)	Owne	er/Operat	18. Mother's Nam	ne (First Midd		staurant en Surnama)						
and	d be fi	To Be	George Carl Reeves Sr.			Mallie N			ŕ						
ar	2 should and Men is marke aumatic	ř	19a. Informant's Name/Relationship (Type. Print)	19b. Mailin	g Address (Street	and Number or Ru				Zip Code)					
Ž,	s 1 and 2 should f Health and Mer tem 27 is marke other traumatic		Richard Reeves/ Son				hurchy Date			and 21028					
פֿב	Pages 1 nent of H ant: If ite ary or ot		Burial /2   Cremation 3   Hemoval from State		sition (Name of natory or other place	1			Location - City of						
baltimor			4 Doneyon 5 Ophner (Specify) Harf  21. Signature of Funeral Service Ligensee			erdeen,	Maryland								
ñ	permit. Departe Imports any Inj		Hand KIM eng to	fund K I and 1317 Cokesbury Rd.,											
			23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line.	Do not ente	er the mode of dyir	ng, such as cardiad	or respiratory	arrest,		Approximate Interval Between Onset and Death					
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)  a. Due to (or as a conseque	1 /	rtery	Diseo	se			50 years					
	Examiner		Denci To	SU	Cficie	nay				10 years					
ŀ	्रं ४ अ	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	ence of):						1					
	and I-trans	Examiner	Cause (Disease or injury that initiated events c	ence of):											
58/6U	ificate be executed a physician and as the burial-transit	cal E		,											
	rtificati ng phy as the	Medical	IF FEMALE:												
o R	w requires that the death certific been signed by the attending p should be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome pf pregnant 1 □ Live birth 2 □ Fetal c	death 3	Ectopic pregnancy	у			23d. Date of d Month	elivery Day Year					
	the de y the a	ysic	1 Yes 2 No 4 Pregnant at time of dea 9 Unknown 9 Unknown	aui 5L	Other (specify) _										
ν, J	s that gned b	by Pr	Part II. Other significant conditions contributing to death but not result	ing in the un	iderlying cause giv	en in Part I.	23e. Di	d tobacc	o use contribute	to the cause of death?					
ora	require sen siç nould b	ted l					1[	] Yes		Probably 4 Minknown					
Č	The law te has boage 2 sh	Completed					24a. Wa au pe	as an topsy rformed:	prior to	autopsy findings available completion of cause of					
Vital Records,			25. Was case referred to medical			26. Place of Dea	1□ Yes	2 1	No 1 □ Ye	es 2 No					
	ysician: nis certific director,	To Be	examiner?	R/Outpatient	t 3□ DOA Oth	or.			6 ☐Other (Sp	pecify)					
o uc	Attending Physician: r death. ector: After this certific by the funeral director,		1 Natural 5 ☐ Pending (Month, Day Year)	28b. Time of Injury	28c. Injur Wor	ryat rk? Yes 2∐No	28d. Describ	e how in	jury occurred						
DIVISION	Attend death ctor: /	ficat	2 Accident investigation 3 Suicide 6 Could not be determined suiting attractions of the could not be determined suiting attractions of the could not be determined.	ne, farm, stre		res ZLINO	28f. Location	(Street	and Number or i	Rural Route Number,					
2	tal or / s after al Dire ed in b	Certification:	4 Homicide determined building, etc. (Specify)				City or 1	own, Sta	ate)						
	Hospit 24 hour Funer tely fill	Medical (	29a. Certifier (Check only one)  Check only one)  Check only one)  Check only one)												
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the ft	Med	one) and manner stated.  29b. Signature and title of certifier		29c. Licens	se number		29d. (	Date signed (Mo.	nth, Day, Year)					
			Duit Helpis m	0	AT2	4389	46	00	tober	28,2006					
	15		30. Name and address of person who completed cause of death (Item 2	4	_ ^	20000	1 Ihm	1.7.	e.1 .	ND					
	Sta	te		Inic		mona	1 105	V112	/ /	v ()					
	Registr		NOV 0 1 2006 Beau St												

Paul Dana Raymond

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

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		1- For State Registrar		Reg. No. 2000 3470									
Physicia		Decedent's Name (First, Midd)	th	3. Time of Death									
Medical Exami	ner	Paul D. Raymo	nd					Month October 1	Day Year 5, 2006	1405 hrs			
		4a. Facility Name (if not institution	on, give street and num	ocation of Death	4c. County of Death								
		Clark Road and Route				Jessup			Anne Aru				
Funeral	-	5. Social Security Numberunk	6 Sex 7	'. Age (In yrs. la	ast hirthday)	If Under 1 Year	If Under 24Hrs.	8 Date of Bi	th/MM/DD/VVVV	Birthplace (State or Foreign			
Director		o. coolar ocounty reamber (111)		. rigo (iii ) io io		Months Days	Hours Min.	7		Country)			
Director	l		1 X M 2 F		44 Yrs.			Sept	16, 1962	Maryland			
		Usual Residence of Decedent											
v any		10a. State 10b. County		10c. City,	Town or Location	on				10d Inside City Limits			
nd shov	닐	MD Anne	Arunde1	İ	Jessu	.p				1 Yes 2 X No			
Aaryland 28a-f show 1 at once.	힜	10e. Street and Number				10f. Zip Code		1	0g. Citizen of Wha	at Country?			
rth the Maryland 23a or 28a-f sho notified at once.	Director	7810 Clark Ro	ad #C-16		20794 USA								
23a noti		11. Marital Status		dent Ever in U.	S 12 W/as	Decedent of Hispa				American Indian, Black,			
ath v tems	Funeral	1 Never Married 2 X M		ces?		s, specify Cuban, I			White,				
The specific results of the sp									07	1			
								-11		white			
036 thin 72 hours ne. than "natur tedical Exami	Completed	Elementary/Secondary (0-12)				st of working life. [			16b. Kind of Bus	iness/industry			
n 72 n an 'cal	e			4 01 5+)									
withi iene.	틹	12	0		auto	mechanio			automo	tive			
15-00; Thed with Hygiene, If other th		17. Father's Name (First, Middle							Maiden Surname)				
21215-0036 And be filed within 7 Mental Hygiene. marked other than c event, the <u>Medica</u>	a	Allen Patricl			_		Doris Am			Swall consideration			
D 2. should and M. 7 is martice	ျ	19a. Informant's Name/Relations	ship (Type, Print)		19				mber, City or Town				
MD id 2 sho ulth and m 27 is aumati	-1	Tom Amrein/u	ncle					wings N	Mills, MD	21117			
	20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or crematory or other place)												
Baltimore, permit Pages I an Department of He Important: If ite		Data 2 Constant of											
t Paritment y or	- 1				22 N	ame and Address o	of Eacility						
Baltimore permit. Pages I Department of I Important: If	21. Sa nature of Funer)   Service Licensee   Property   State Anatomy Board 655 W. Baltimore State Baltimore Baltimore Stat												
	_]	230 Phil Estartha discoor	1000	upad the death		timore, N			and about orbins	rt Approximate Interval			
Physician /Medical	failure. List only one cause on each line												
Examiner	1	Immediate Cause (Final disease a, Multiple Injuries											
	- 1	or condition resulting in death)	Due to (or as a	consequence of	f):								
to managed to	L	Sequentially list conditions,	b										
	<u>ë</u>	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a	consequence of	f);								
	Examiner	(Disease or injury that initiated events resulting in death) Last	Due to (or as a	consequence of	f):		_						
xecuted n and - transit		events resulting in death) Last	d.	4-2	•,•								
execu in and	n/Medical	UNPENDED	AMENDED			·							
760, ficate be exe g physician a	edi												
8760, tificate bong physicas the burner as t	₹	IF FEMALE: 23b. Was decedent pregnant in t		utcome of pregr		al death 3	Ectopic pregnar	nev	23d. Date of d Month	delivery Day Year			
68 certi ndin ise as		past 12 months?		nt at time of de	2 Fet			icy	Wichtij	Day Teal			
Box 68 e death certi	Şi	1 Yes 2 No 9 Un	known 9 Unknov		⊃ [ Oth	er (Specify)			3				
O. B at the da i by the tached	Physicia	Part II. Other significant condit	tions contributing to	death but not re	esulting in the ur	derlying cause giv	ven in Part I.	23e. Did to	obacco use contrib	ute to the cause of death?			
P.C that	ď		Ū		ŭ	, , ,		1 Ye	s 2 V No 3	Probably 4 Unknown			
Division of Vital Records, P.O. rst of vaterding Physician: The law requires that it is after death.  al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detected.	Completed	-						1000000					
ords,	ie e							24a. Was autor	osy pr	ere autopsy findings available ior to completion of cause of			
ec he la ite ha	튀							perfo 1 <b>✓</b> Yes		eath? ✔ Yes 2 No			
tal Rection: The certificate		25 Was case referred to medical	i T			26 Place o	of Death (Check of	Bear and		100 2 110			
Vital Rec ysician: The I his certificate I	a	examiner?	Hespital:	patient 2	ER/Outpatient		ther:		Residence 6	Other: Seene			
Phys	욘	1 Yes 2 No 27. Manner of Death	28a. Date o		28b. Time of In		`		how injury occurre	·			
n of ding Ph	Ë	1 Natural	Oct Month	Day Year)	1400 hrs				fixed object co				
Sion tten death ctor:	ä		stigation										
Y. Safter after Dire	١ĔΙ		id not be	of Injury - At ho	ome, farm, stree	t, factory, office bui	ilding, etc.	28f Location ( or Town, S	Street and Number	r or Rural Route Number, City			
Divis	Certification:	4 Homicide	rmined (Specify)	Local Stree	et		k	Clark Road	and Route 17	5, Jessup, MD			
Division of Vital Records, P.O. Box 68760, for the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. For the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transitions.			hysician: To the best										
To the Hos within 24 h To the Fun	Medical		aminer: On the basis of and manner sta		nd/or investigati	on, in my opinion, o	death occurred at	the time, date	and place, and du	e to the cause(s)			
5 ± 8 ± 8	Βe	29b. Signature and title of certific				29c. License	number		29d. Date signe	d (Month, Day, Year)			
		Tabille	22//			O.C.M	I.E.		October 16,	2006			
		00 No.	/ _	•	22-1				L				
		<ol> <li>Name and address of persor Zabiullah Ali, M.D.</li> </ol>	n who completed cause Assistant Medica	•		Street, Baltin	more MD 213	201					
	لب		1144										
S Regis	tate	31. Date filed (Month, Day, Year)	107	gistrar's Signatu	The Algoria	13							
Negis	LUC U	125 11:121	CUUU MAN	Date filed (Month, Day, Year)  NOV 0 1 2006  32 Registrar's Signature									

			7 _ State	artment of Health and Mental Hygiene ortificate of Death
			Registrar  1. Decedent's Name (First, Middle, Last)	2. Date of Death 3. Time of Death
	Physic /Medi		Katherine Swindell	Month Day Year October 25, 2006 01:45 PM
y.	Exami		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death  4c. County of Death
	<del>opezi o o o o</del>		St. Elizabeth Rehab & Nursing Center  5. Social Security Number 6. Sex 7. Age (In vrs. last birthday	Baltimore Baltimore
П	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, 1 1 M 2 1 F 89 Yrs.	Months Days Hours Min. (Month, Day, Year)
	D		Usual Residence of Decedent	10/19/1917 Maryland
	arylan show d at	_	Maryland Baltimore 10c. City, Town or L Baltimore Baltimor	rod. Inside Oily Limits
	the Market 1	<b>Funeral Director</b>	Daicinoi	
	with i	ä	10e. Street and Number	10f. Zip Code 10g. Citizen of What Country?
	death ms 23	Jera	3310 Benson Avenue, Apartment 203  11. Marital Status  12. Was Decedent Ever in U.S.  13.	21230   United States  Was Decedent of Hispanic Origin? (Specify Yes or No-   14. Race - American Indian,
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	y Fur	If Yes, Give	Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  1 ☐ Yes 2 ☑ No Specify:  1 ☐ Yes 2 ☑ No Specify:  Specify: White
21215-0036	2 hour atural cal Ex	Completed by	15. Decedent's Education 16a. Dece	dent's Usual Occupation 16h Kind of Pusingsylladustry
215	thin 7; e. an "n Medi	ple	(Specify only highest grade completed) (Give life.	kind of work done during most of working DO NOT use retired)
7	ed wi ygien ner th	Con	12 Home	maker Own Home
Maryland	d be fil	Be	17. Father's Name (First, Middle, Last) Edwin Morris Foard	18. Mother's Name (First, Middle, Maiden Surname)  Katherine Pauline Brown
ary I	shoul	P L	19a. Informant's Name/Relationship (Type. Print) 19b. Maili	ng Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Ž	and 2 ealth a n 27 is		Edwin Morris Foard, III 2309	Dalib Road, Finksburg, Maryland 21048
Baltimore,	ges 1 t of He If item or oth			matory or other place)
E E	rtmen rtmen rtant;		A□Donation 5 □Other (Specify) BayV1eW (	
Ba	Depa Impo any i		21 Signature of Funeral Service Licensee	2. Name and Address of Facility Hurbard Funeral Home, Inc. 1107 Wilkens Avenue, Baltimore, Maryland 21229
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter shock or heart failure. List only one cause on each line.	er the mode of dying, such as cardiac or resultatory arrest, Approximate
QI.	Physician		Immediate Cause (Final disease or condition	avail in tall Dan Journ
1	/Medical Examiner		Due to or as a consequence of):	avilion factorian 20 years
		er	Sequentially list conditions, if any, leading to immediate b. Due to (o/ss/ consequence of):	20 Gens
	cuted A	Examiner	Sequentially list conditions, if any, leading to immediate cause. Either underlying Cause (Disease or injury that initiated events  c.	
Ö,	icate be executed physician and	Ë	resulting in death) Last  Due to (or as a consequence of):	
98760	flicate be executed physician and	edical	d	
Box	leath certifi attending l		IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome pf pregnancy	23d. Date of delivery
	death le atte ed for	Physician/M	in the past 12 months?  1 □ Yes 2 □ No   1 □ Yes 2 □ No   1 □ Yes 2 □ No	Ectopic pregnancy   25d. Date of delivery   25d. Dat
J O	lat the	Phys	9 ☐ Unknown 9 ☐ Unknown	
ďS,	uires that the de signed by the a Id be detached f	þ	Part II. Other significant conditions contributing to death but not resulting in the un	
Ö	w requir been si should	letec		
ital Kecords,	sician: The law requires that the death certificate has been signed by the attending irector, page 2 should be detached for use as	Completed		24a. Was an autopsy findings available prior to completion of cause of death?
ıra	clan: ertifica ctor, p	Be C	25. Was case referred to medical examiner?	1  Yes 2 No 1 Yes 2 No 26. Place of Death (Check only one)
<u>_</u>	호 흥 교	၉	1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatien	— Justing Figure 5 — Nesiderice 6 — Other (Specify)
00	ding Phys h. After this funeral din	ijon	27. Manner of Death  La Natural 5 □ Pending (Month, Day Year)  2 □ Accident investigation  2 □ Accident	28c. Injury at Work? 28d. Describe how injury occurred
UIVISION	Atten r deatl sctor: by the	fical	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, str	
5	s after	Certification:	4 Homicide determined building, etc. (Specify)	City or Town, State)
	To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After the completely filled in by the funeral	edical (	Medical Examiner: On the basis of examination and/or in	occurred at the time, date and place, and due to the cause(s) and manner as stated.  vestigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
	Fo the within : Fo the comple	≥	29b. Signature and title of Certifier	29c. License number 29d. Date signed (Month. Day, Year)
)			- / T/C /UN	N52746 Oct. 27/2006
	V		30. Name and address of person the completed cause of death (Item 23a) (Type, I	DS2746 Oct., 27/2006 Residen Chine lang Deltemy
	Sta		31. Date filed (Month, Day, Year)  32. Registrar's Signature	no de la la la la la la la la la la la la la
	Registra	-	31. Date filed (Month, Day, Year) 32. Registrar's Signature NOV 0 1 2006	

			1 - For State Registrar		artment of Health and ertificate of Death		iene 2006	34706							
	Dhysisi		Decedent's Name (First, Middle, Last)			2. Date of Deat Month	Day Year	3. Time of Death							
	Physicia /Medic		Elsie MARIE Schn			Ochber		4:05 AM							
	Examin	er	4a. Facility Name (If not institution, give street and Harbor Haspital	num <i>ber)</i>	4b. City, Town, or Location of Deat	he,	4c. County of Death N/A								
ı	Funeral		5 Social Security Number 6. Sex	7. Age (In yrs. last birthday	If Under 1 Year If Under 24 Hrs	8. Date of Birth (Month, Day,	· · · · · · · · · · · · · · · · · · ·								
	Director		212-42-9857 1 <sup>1</sup> M 2 D	96 Yrs.	Months Days Hours Min.	0ct 21	. 1910 Mai	ryland							
	PL &		Usual Residence of Decedent  10a, State 10b, County	10c. City, Town or L	ocation			10d. Inside City Limits							
	Aaryla f sho	٥	Maryland Anne Arundel	,	altimore			1 ☐ Yes 2X No							
	28a-	Directo	10e. Street and Number		10f. Zip Code	1	0g. Citizen of What Co	untry?							
	death with the Maryland rms 23a or 28a-f show r must be notified at	al D	621 Luther Street		21225	USA									
	2 hours after death with the Marylan eturel, or iteme 23a or 28a-f show cel Exemiliar must be rodiffed at	Funeral	Armed	ecedent Ever in U.S. 13. Forces?	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer	pecify Yes or No- to Rican, etc.)	14. Race - Ame Black, White								
9	hours after turel, or ite	by Fi	1 Never Married 2 Married 1 Yes, 3 M Widowed 4 Divorced Year of	es 2 No Give r Dates:	1 ☐ Yes 2 ☑ No Specify:		Specify: White								
2-0036	2 hou		15. Decedent's Education	16a. Dece	edent's Usual Occupation		16b. Kind of Business/								
בוז	thin 7.	Completed	(Specify only highest grade complete Elementary/Secondary (0-12) Colleg	e (1-4or 5+)	e kind of work done during most of wo DO NOT use retired)										
7	filed within 72 Hygiene. ither then "ne ent, the Mudic		17. Father's Name (First, Middle, Last)	0 Ho	memaker	ne (First, Middle, M	Housewife &	Motner							
Maryland	ed far b	o Be	irvatka												
2	should ind Men marke umatic	스	John S  19a. Informant's Name/Relationship (Type, Print)	irvatka 19b. Mail	ing Address (Street and Number or Ri	ural Route Number	; City or Town, State, 2	Tip Code)							
	s 1 and 2 should f Health and Mer Item 27 le marke other traumatic		Frederick John Schmidt	(Son) 621	Luther St., Balt	imore, Ma	aryland 2	21225							
o o			20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from		matory or other place)		20c. Location - City or	1101							
Baltimore,	mit. Pages pertment of hoortant: If Ite		4 ☐ Donation 5 ☐ Other (Specify)	Glen Hav			Glen Burnie								
Ba	permit. Page Depertment of Important: If eny injury or once.		21. Signature of F. heral Service Licensee Kevin E Ecker McCully-Polyniak Funeral Home, P.A. 21225												
			23a. Part1. Enter the disease, or complications the shock, or heart failure. List only one cause of	at caused the death. Do not en	iter the mode of dying, such as cardia	or respiratory arre	est,	Approximate Interval Between							
	Physician		Immediate Cause (Final disease or condition	PSIS				Onset and Death  2 day 5							
	/Medical Examiner		resulting in death)	to (or as a consequence of):				1							
	Xdiffilio	-	Sequentially list conditions, b. Duality, leading to in mediate	to lor ar a consequence of	1			I week							
	uted J ansit	Examiner	causé. Enter Underlying Cause (Disease or injury that indicated events  c. Acute Renal Failure												
ڪ ي.	exec en an			to (or as a consequence of):											
8760	death certificate be executed e ettending physicien and id for use as the burial-transit	dical	d			<del></del>									
×	eath certifica ettending pt I for use as t	/Med	IF FEMALE: 23c. If yes.	outcome of pregnancy			23d. Date of del	Nerv							
Rox	Seath of ettern of for u	Physician/M	23b. Was decedent pregnant 1 Lin in the past 12 months? 4 Pr	re birth 2 Fetal death 3 egnant at time of death 5	□Ectopic pregnancy □ Other (specify)		Month	Day Year							
o.	at the de by the tached	hys	9 □ Unknown 9□ Un	nknown											
ecords, t	as this	þ	Part II. Other significant conditions contributing t		underlying cause given in Part I.		oacco use contribute lo es 2 ☐No 3 ☐ Pr	the cause of death?  bbably 4 Unknown							
Ö	aw requir as been si 2 should I	Completed	Congestive Heart	Failure		24a. Was a		topsy findings available							
1	The age	E O				perform		_/							
Vital	certilice rector, p	Be	25. Was case referred to medical examiner?			ath (Check only on	Θ)								
<u>o</u>	Physi this o	2		☐Inpatient 2☐EP/Outpatiente of Injury 28b. Time			ence 6 Other (Spec	cify)							
0	Attending Physician: r death. ector: After this certilic by the funeral director,	tlon	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	fonth, Day Year) Injury	of 28c Injury at Work?  M 1 Yes 2 No		,,								
Division	P 등 등 C	Certification:	3 Suicide 6 Could not be determined 28e. Pl	ace of Injury - At home, farm, si ulding, etc. (Specify)	treet, factory, office	281. Location (Street and Number or Rural Route Num City or Town, State)									
	To the Hospital of within 24 hours eff To the Funeral Discompletely filled in		29a. Certifier 1 Certifying Physician: To	the best of my knowledge, dea	th occurred at the time, date and place	e, and due to the ca	ause(s) and manner as	stated.							
	HOS 124 h	Medical	(Check only 2 Medical Examiner: On th		nvestigation, in my opinion, death occu										
	To th Withir To th comp	ž	29b. Signature and the of certifier	11	29c. License number		9d. Date signed (Monti	n, Day, Year)							
)			1/w6 late	1 MD	P20756		10/30/0	6							
	5		30. Nam and address of person who completed of	ause of death (Item 23a) (Type	enover Street. Bu	1 Karaca	44A =	n -							
	Sta	te	31. Date filed (Month, Day, Year) 3:	2. Alighstrar's Signature	prover sprict. 130	" none	712	25							
	Registr		NOV 0 1 2006	Drew B h	1948A										

State of Maryland / Department of Health and Mental Hygiene 2 1 1 5 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Dav Mahendra Κ. /Medical October 28, 2006 12:29 P 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Laurel Regional Hospital Prince George's Laurel 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral**  Birthplace (State or Foreign Country) 1X M 2□ F Director Yrs. 052-50-1560 65 Jan 16, 1941 India Usual Residence of Decedent with the Maryland 10a State 10b. County 10c. City, Town or Location na 23a or 28a-f show 10d. Inside City Limits Directo 1 Tes 2 No Maryland Montgomery Burtonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 15104 Swiss Stone Court Pages 1 and 2 should be flied within 72 hours after death nent of Health and Mental Hygiene. and 1 fem arked other then "naturel", or Itema 23. by Funeral 20866 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-It Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. the Medical Exeminer 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No It Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced Specify: Asian-Indian Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 5+ Financial Manager Accounting other treumatic event, 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Sumame) Kantilal ဥ Lalitaben Shah 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sharmistha Shah/wife 15104 Swiss Stone Court Burtonsville, Maryland20866 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of H Important: If Its any Injury or of once. 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 4 ☐ Dogation 5 ☐ Other (Specify) West Arundel Crematory 10/30/06 Odenton, Maryland 21. Signature of Funeral Service Licensee uanta o Donaldson Funeral Home & Crematory, P.A. nomao 1411 Annapolis Road Odenton, Maryland 21113 23a. Part 1 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Coronary Artery Disease Unknown /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine The law requires that the death certificate be executed ed by the attending physician and detached for use as the burial-transit resulting in death) Last Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy 4☐Pregnant at time of death Month Day Year 5 Other (specify) P.0. 9 Unknown 9 Unknown s been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, à Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy tindings available prior to completion of cause of death? 24a. Was an page 2 has autopsy performed? certificate 1 Yes 2X No : After this certifica e funeral director, p Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death Check only one Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 ☐ Yes 2X No 2 ER/Outpatient 3₹ DDA 27. Manner ot Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 X Natural 5 Pending investigation Injury death. М within 24 hours after death To the Funeral Director: the 2 Accident 1 TYes 2 TNo 3 ☐ Suicide 6 Could not be determined in by t 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide filled \( \frac{\text{\tin}\text{\tett{\text{\tett{\text{\tet 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D 23181 26 MI October 29, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 704 Corman Avenue #T-1 Laurel, Maryland 20707 Bhoirs; M.D. 32 Registrar's Signature 31. Date tiled (Month, Day, Year) State NOV 0 1 2006 Registrar

State of Maryland / Department of Health and Mental Hygien® 34708 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Martha Adelaide Sager 7:04 PM M October 29, 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Suburban Hospital Bethesda Montgomery 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) 02/22/1919 Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 K F 87 Months Days Hours 578-12-6042 Director PA Usual Residence of Decedent with the Maryland 10b. County 10c, City, Town or Location show 10d. Inside City Limits ir than "natural", or Items 23e or 28a-f shov the Madical Examinat must be notified at MD Director Montgomery Bethesda 1 Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10517 Aubinoe Farm Dr. 20814-USA death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Race - American Indian, Black, White, etc. e filed within 72 hours after d il Hygiene. other than "natural", or Item 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No δ Specify: 3 Widowed 4 □ Divorced Specify White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Education Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed will Department of Health and Mental Hygiens Important: If item 27 is marked other tha any injury or other traumatic event, Ins.) once. Professor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Frank Aloysius Corcoran Mary Adelaide Hughes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Christine S. Holderness/Daughter 2213 North Dearing St. Alexandria, VA 22302-20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Nov 1 1 ☐ Burial 2 ☐ Gremation 3 ☐ Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 2006 Beltsville, Maryland 21. Signature of Funeral Service License Rapp Funeral & Cremation Services 933 Gist Ave. Silver Spring, Maryland 20910-23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Atherosclerosis /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Causs (Lissate of injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Year Month Day 4 Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA this filled in by the funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of Certification; 28d. Describe how injury occurred After Hospitel or Attending 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation after death Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours a To the Funeral C 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D005701 10/29 06 0 30. Name and address of person who completed clause of death (Item 23a) (Type, Print) Oza 8600 Old Greorgetown Rd . Bethesda, MD20814 31. Date filed (Month, Day, Year) 32. Registrar's Signature 2006 Registrar

Please Type or Print in Black Indelible Ink Ensure All Copies Are Legible. AMEND TTEM Ioa PRR FH Cool 11-01-06 vt. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 34709 Certificate of Death Reg. Nor 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month Day Year **Physician** EDWARD 5:38 AM SHOCHET OCTOBER IRVING 31 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HUSPITAL CANDALLS TOWN BALTIMORE NORTH WEST If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 04/09/1924 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** 1 M 2 F Months 82 Director 214-14-2972 Usual Residence of Deced MD with the Maryland 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits worle If is marked other then "naturel", or Iteme 23a or 28a-f shov treumatic event, the Mudical Exeminar must be notified at 1 ☐ Yes 2 ☐ No Director BALTIMORF BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7910 WINTERSET AVENUE 21208 U.S.A. permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: if Item 27 is marked other then "naturel; or Iteme 23e eny injury or other treumatic event, the Mudical Examiner mental pinge. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes 2 No WWII 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: WHITE þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) PROPRIETOR PROPIETOR PHARMACY 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be SHMUL SHOCHET **MIRIAM** LEVIN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CAROLYN SHOCHET / WIFE 7910 WINTERSET AVENUE - BALTIMORE, MD 21208 20b. Place of Disposition (Name of cametery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) BETH EL MEMORIAL PARK 10/31/2006 RANDALLSTOWN, MD 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licensee Matt Len 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ATHERUSCLEROTIC CARDIOVASCULAR DISEASE /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed Due to (or as a consequence of) the attending physician a hed for use as the burial-Division of Vital Records. P.O. Box 68760. Physician/Medicai IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Day 5 Other (specify) 1 ☐ Yes 2 ☐ No detached 9☐ Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by AUF to Clostridium 3 Probably 4 Nonknown 2 No 1 Tyes 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an page 2 autopsy 1 Yes 2 No the Hospital or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Unpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 100 ဥ 2 ER/Outpatient 3 DOA this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending investigation Injury 1 Yes 2 No 2 Accident Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours a To the Funerel D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year) 057722 OCTOBER 31 M.D. NORTH WEST HOSPITAL 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ALCHARDSON M.P. 5401 OLD COURT ROAP RANDAUSTUWN, MO ZII33 LEUNARD 32. Signature 31. Date filed (Month, Day, Year) State 0 1 2006 Registrar

			1 - For State Registrar	State of Mar	yland		irtment tificate			ınd Me		ene 0 0	6	34710	
	Physici	an	1. Decedent's Name (First, Middle, Las	-		0				2	<ol> <li>Date of Death Month</li> </ol>		Year	3. Time of Death	
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	and and		Usual Residence of Decedent  10a. State 10b. County	1	0c. City, T	own or Lo	cation			-			10	d. Inside City Limits	
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980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: if tiern 27 is marked other than "natural", or items 23a or 28a-f ehow any injury or other traumatic event, the Machal Eschling frault to notified at once.	by Funeral Director	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 🛣 Widowed 4 ☐ Divorced	12. Was Decedent Eve Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	er in U.S.	11	Vas Decede Yes, specif	y Cuban	panic Orig , Mexican, Specify:	in? (Speci Puerto Ri	fy Yes or No- can, etc.)	Black,	14. Race - American Indian, Black, White, etc. Specify: White		
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Maryland	ould be Mental arked c	To Be		Benson					Aı	nnie	Name (First, Middle, Maiden Sumame) Lie Stewart				
Mar	12 sh h and 7 is rr traum		19a. Informant's Name/Relationship (7)									City or Town, Si			
<u>6</u>	Pages 1 and neut of Healint: If item 2 iry or other	27	Terry Schweiger / son 215 Hilltop Road Baltimore, Maryla  20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location												
I I			20a. Method of Disposition  1 Disposition (Name of cemetery, crematory or other place)  4 Donation 5 Other (Specify)								1 -	altimore			
Baltimore,	permit. I Departm Importa any inju	1	Cedar Hill Cemetery 11/3/2006 Baltimore, Maryland  21. Signature of Funeral Service Licensee  22. Name and Address of Facility Gonce Funeral Service, P.A.  4001 Ritchie Highway Baltimore, Maryland 212											P.A.	
· 10-	40344		23a Part Enter the disease or comp	ications that caused the	a chath [								ryla	and 21225 Approximate	
1	Physician /Medical Examiner		23a. Part. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Downwork  Due to (or as a consequence of):												
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ds, P.	gne	by	Part II. Other significant conditions con	ntributing to death but n	ot resulting	g in the un	derlying cau	se given	in Part I.		23e. Did toba		ute to the	cause of death?	
Record	sw requir s been si s should	olete									24a. Was an	24h We	re autoni	sy findings available	
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Vital	sician: Th certificate rector, pag	Be	25. Was case referre to medical examiner?	lospital:				Other:			Check only one)				
o	Phys or this oral di	٦. <u>۲</u>	1 Yes 2 No	1 ☐ Inpatient  28a. Date of Injury		Outpatient  Time of		. Injury a	4 Nurs			ce 6 Other	(Specify)	-	
Ö	Attending Physician: r death. ector: After this certific. by the funeral director,	atlor	1 ☐Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Ye	ear)	Injury	M	Work?	s 2 □ No		. 00301100 1104	injury occurred			
-		Certification:	3 Surcide 6 Could not be determined	28e. Place of Injury building, etc. (S	At home, Specify)	farm, stre	et, factory, o	office		28f.	Location (Stre City or Town,	et and Number State)	or Rural	Route Number,	
	To the Hospital o within 24 hours at To the Funeral D completely filled in	edical	29a. Certifier 1 Certifying Physical Check only one) 2 Medical Exemin	sician: To the best of m ner: On the basis of exa and manner stated	amination	ige, death and/or inve	occurred at lessing at less to the second at	the time, my opin	, date and lion, death	place, and occurred	due to the cau at the time, date	se(s) and mann and place, and	er as star	ed. ne cause(s)	
)	within Comp	Σ	29b. Signature and title of certifier	1. Al	us 1	no		icense n		0		Date signed (/			
	6		30. Name and address of person who co	mpleted cause of death	1 (Item 23a	a) (Type. P	rint)			-		1	,	7, 2006 5MOZ110,	
	)		MICHAELI	A ANKR		10	864 V	erc	RANS	H161	INAYN	11 weks	עוע	eMOZILO.	
	Stat		31. Date filed (Month, Day, Year)	32. Registrar's		. 1	cette o			· v = f	1		- /	7 /	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] [] [ 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month SMOLAK DCTOBER 27 2006 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death HARBOR HOSPITAL BALTIMORE N/A | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Feb. 0, 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 □ M 2 🖺 F 219 30 8506 80 Yrs. Ukraine Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits N/A Baltimore Maryland 1X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1519 Filbert Street U.S. 21226 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: White Specify: 3 AWidowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 6th Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Unknown Andruch Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Martha Etheridge / Daughter 108 Fox Hound Drive Glen Burnie, Maryland 21061 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (\$pecify) St. Michael Ukranian 10/31/2006 Baltimore, Maryland macai Savis Licenspe 22. Name and Address of Facility Gonce Funeral Service, P.A. 21. Signature 4001 Ritchie Highway Baltimore, Maryland 21225 Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest

Examiner or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, signed by the a d be detached f within 24 hours after death.

To the Funerel Director: After this certific completely filled in by the funeral director. To the Hospitei

**Physician** 

/Medical

Examiner

10a State

**Funeral** 

Director

28a-f show

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or items 23a

permit. Pages 1 and 2 should be filed within 72 hours atter death 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural; or itema 23a any Injury or other traumatic event, the Medical Examinat must appear.

**Physician** /Medical

Baltimore, Maryland 21215-0036

Director

Funeral

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Completed

Be

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	shock, or heart failure. List only	one cause on each line.	DO HOL GIRGI WIGH	inde or dying, such as cardia	c or respiratory arrest,		Interva	al Between					
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Medical Certification:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation												
Certific	3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Specif	ural Route	Vum <i>ber,</i>									
edical	29a. Certifier (Check only one)  11 Certifying Ph 2 Medical Exam	hysician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as state miner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the and manner stated.											
Σ	29b. Signature and title of certifier	29c. License number 29d. Date signed (Month, Day, Year) 228510 OCTOBER 27											

HANOUER STREET BALTIMORE, MD

00

DHMH 17 Rev 1/2001

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2006

CHANGPING

31. Date filed (Month, Day, Year)

3001

32. A gistrar's Signature

			r lease 1	State of Marylan				-	•				
		1	For State Registrar	olate of Marylan		tificate of			2006	34712			
фе			Decedent's Name (First, Middle, Last)					2. Date of Dea	ıth	3. Time of Death			
Phys /Me	icia: dica		M	Margaret G. S	chwarz			OCTObe	Day Yea	/ / / / / / / / / / / / / / / / / / / /			
Exan			4a. Facility Name (If not institution, give st.	10 11 -1	5.tal		Location of Death	1	4c. County of Death				
			5. Social Security Number 6. Sex	vare HOSI	21/al	If Under 1 Year	Sedale If Under 24 Hrs.	2 Date of Birth	Jairimore				
Funer Directe				7. Age (In yrs).	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day Jan. 16	r, Year) (	irthplace (State or Foreign Country) ary Land			
		-	Usual Residence of Decedent					Julii 10	, 1925 110				
arylan show	Ī.		10a. State 10b. County Maryland Baltimore		y, Town or Loo arkvi1					10d. Inside City Limits 1 ☐ Yes 2 ♣ No			
he Mi		9010	10e. Street and Number	e 1	arkvii	10f. Zip Code			10g. Citizen of What				
be lied within 72 hours after death with the Maryland tall hygiene. It all hygiene. d other then "neturel", or items 23a or 28a-f show event, the Maryland fraginar mount be notified at		Funeral Director	8830 Walther Blvd	d. Apt. 311		2123	34		U.S.	Southly :			
death Cms 2%		era		Was Decedent Ever in U.     Armed Forces?	S. 13. V		lispanic Origin? (Si an, Mexican, Puert	pecify Yes or No-		nencan Indian,			
after or Ite	L		1 Never Married 2 Married	1 ☐ Yes 2 <b>X</b> No If Yes, Give		Yes, specify Cuba	Specify:	o Hican, etc.)					
urel',	:	D D	3 ☑ Widowed 4 □ Divorced	Year or Dates:					VV	hite			
n 72 n		Completed	15. Decedent's Educi (Specify only highest grade	completed)	(Give I	ent's Usual Occup kind of work done o OO NOT use retired	ation during most of wor d)	king	16b. Kind of Busines	s/Industry			
d with jiene.		E	Elementary/Secondary (0-12)	College (1-4or 5+)		maker			Own Home				
d be titled and be titled and be titled by great, compared by great,		Bec	17. Father's Name (First, Middle, Last)						Maiden Sumame)				
should b nd Ment marked marked	1	0	John G	Dickard									
VICAT 12 sh 12 sh 12 m 1 is m 1 is m			19a. Informant's Name/Relationship (Type Marianne Schwarz			g Address <i>(Str</i> eet naves Cot			r, City or Town, State , Maryland				
is 1 and 2 should be liked within 72 hours after death with the Marylan is 1 and 2 should be liked within 72 hours after death with the Marylan is earth and Mental hygiene.  The 27 is marked other then "neturel", or items 23a or 28a-1 show other traumatic event, the Medical Exercities manage or citied at		-	20a. Method of Disposition		_	sition (Name of natory or other place		Date	20c. Location · City				
J 0 0			1 ☐ Burial 2 X Cremation 3 ☐ Re 1 ☐ Donation 5 ☐ Other (Specify)			natory or other plac Crematory	i i	8/2006	Baltimore,	. Marvland			
Dattimor permit. Pages Department of Importent: If it any injury or or	9	-	21. Signature of Funeral Service Licenses		/ 22	Name and Addre	ss of Facility G	once Fun	eral Servi	ice, P.A.			
	ouce		Jecome ma	muacult	/					yland 21225			
			23a. Part1. Enter the diseas or complic shock, or heart failure. List only one	ations that caused the deat e cause in each line.	n. Do not ente	er the mode of dyin	g, such as cardiac	or respiratory are	rest,	Approximate Interval Between Onset and Death			
Physicia	_		Immediate Cause (Final disease or condition resulting in death)	_Heart	tailu	ire				1 Hour			
/Medic Examin	_		1	Due to (or as a conseq	vence of):	100				10 hears			
		ē	Sequentially list conditions, if any, leading to immediate	Due our as a consequence	uence of):	10/1				10 0100			
uted d ansit	J)	Examiner	Sequentially list conditions, if any, leading to immediate cause. Einer Underlying Cause (Disease or injury that initiated events  Cause (Disease or injury that initiated events)										
fou, e be executed sician and e burial-tiansit	ı	Ĭ	resulting in death) Last	Due to (or as a consed	uence of):								
S S S	:	edical	d.										
death certifica e attending ph	1	/Me	IF FEMALE: 23b. Was decedent pregnant 23	c. If yes, outcome of pregna					23d. Date of d	elivery			
death death e atte	:	Physician/M	in the past 12 months? 1 Yes 2 No	1 Live birth 2 Feta		Ectopic pregnancy Other (specify)	<u></u>		Month	Day Year			
The Cords, P.O. The law requires that the late bas been signed by the page 2 should be detached.	1	hys	9 Unknown	9∐Unknown									
res th signed be de		2	Part II. Other significant conditions cont	ributing to death but not res	ulting in the ur	iderlying cause giv	en in Part I,			to the cause of death?  Probably 4 Unknown			
ecords taw requires tas been sign		eted											
The taw ate has page 2 s		Completed						24a. Was a autop perfor	sy prior to med? death'				
		၁ ၂	25. Was case referred to medical				26 Place of Dea	1 ☐ Yes		es 2 No			
Of VITA Physicien: this certific ral director,		0	examiner? 1 ☐ Yes 2 ☑ No Ho	ospital: 1 Inpatient 2 I	ER/Outpatien	t 3□ DOA Oth			ence 6 Other (Sp	pecify)			
on or vitaling Physicien:  After this certific funeral director,			27. Manner of Death  1 Natural 5 Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injur Wor	y at k?		ow injury occurred				
IVISION  I or Attending after death.  Director: After in by the fune		ertification:	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - At he	omo form otro		Yes 2 □ No	28f Location (S	itreet and Number or	Rural Pouta Number			
lor A after Direc		ertif	4 Homicide determined	building, etc. (Specific	y)	eet, factory, office		City or Tow		nulai nuule vullibei,			
DIVISION  To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the fune		S S	29a. Certifier 1 Certifying Physi	icien: To the best of my kno	wledge, death	occurred at the tin	ne, date and place	, and due to the c	ause(s) and manner	as stated.			
he Ho in 24 he Fu pletel		edical	(Check only 2 Medical Examinone)	er: On the basis of examina and manner stated.	tion and/or inv								
To t To t		Σ	29b. Signature and title of certifier	. 4.00		29c. Licens			29d. Date signed (Mo.				
1				MD			00000		October 2	1,006			
15			30. Name and address of person who cor	_	-0.04		Ra115:000	w Mn	21237				
•	Stat	e	31. Date filed (Month, Day, Year)	32. Ragistrar's Signa	ture	Þ '5	107/11/11/0		4(2)				
Reg	istra	ar NOV 0 1 2006 Program of Specific											

			Please  1 - State Registrar	Type or Print in B State of Maryland	d / Depa		Health a	and Me	ntal Hygi	ien@ () ()	m m t mm	13	
	Physic	ian	1. Decedent's Name (First, Middle, La	<sub>st)</sub> yce Marilyn San		inouto o	, Dodin	2	Date of Death	Day	3. Time of 12:13		
	/Medi Examii	cal	4a. Facility Name (If not institution, given	<u> </u>	ders	4b. City, Town	n, or Location of		ctober	29 200 4c. County of		P. M	
			5106 Kramme Av				ltimore			Anne	Arundel		
	Funeral Director		213 18 9808	Sex 7. Age (In yrs. Ia 1□ M 2ĂF 86	ast birthday) Yrs.	If Under 1 Ye. Months Day		Min.	Date of Birth (Month, Day, lay 31,	1920	9. Birthplace (State of Country) Maryland	r Foreign	
	yland		Usual Residence of Decedent  10a. State 10b. County		, Town or Lo					10d. Inside City			
	8e-1 s	Director	Maryland Anne A	rundel B	altimo						1 🗆 Yes	2 <b>X</b> No	
	death with the Maryland oms 23s or 28e-f show	Dire	10e. Street and Number 5106 Kramme Av	renue		10f. Zip Code	• 1225		10	og. Citizen of Wh	at Country?		
	death ms 23	Funerai	11. Marital Status	12. Was Decedent Ever in U.S	6. 13. \	Was Decedent of	of Hispanic Ori	gin? (Specif	y Yes or No-		American Indian,		
9	after dea or items	F	1 Never Married 2 Married	Armed Forces?  1 Yes 2 No If Yes, Give	+	f Yes, specify C I□Yes 2 <b>X</b> N		i, Puerto Rio	can, etc.)		White, etc.		
9	72 hours after natural', or ite	d by	3 ☐ Widowed 4 🛣 Divorced	Year or Dates:			10				White		
21215-0036	n 72	Completed	15. Decedent's E (Specify only highest gr	ade completed)	(Give	lent's Usual Oco kind of work doi DO NOT use ret	ne during mos	t of working	1	6b. Kind of Busi	ness/Industry		
212	led within ygiene. her than "	Com	Elementary/Secondary (0-12)	College (1-4or 5+)	Mana	ger				Commun	ication		
	be filed tal Hygie d other	Be (	17. Father's Name (First, Middle, Las.							faiden Sumame)			
Maryland	2 should be and Mental is marked craumatic ev	၉	CLar	· · · · · · · · · · · · · · · · · · ·	eroy Sanders, Sr. Ora Marie Th								
Z	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: if Item 27 is marked other than any injury or other traumatic event, the Mone.		Ronald Graham	**		Glaston					are, 21014		
Je,	of Heal		20a. Method of Disposition	CO.	ace of Dispo	sition (Name of natory or other p	place)	Date	-		ity or Town, State		
Ē	Pages ment of ant: if it ury or o		1   Burial 2 □ Cremation 3   Donation 5 □ Other (Speci	THemoval from State   C = 1		L1 Cemet		1/02/	2006 E	Baltimor	e, Marylar	ıd	
Baltimore,	Departi Departi Import any inj		21. Signat fra of Funeral Service Lice	nsee							vice, P.A.		
	603 a a		23a Part 1 Enter the disease of pen	unlications that caused the death				•		·	aryland 21		
	Dhusisian		23a. Part1. Enter the disease, or con shock, or heart failure. List only Immediate Cause (Final	one cause on each line.	1	/ .	/ such as	/	espiratory arre	51,	Interval Betw Onset and D	veen	
	Physician /Medical		disease or condition resulting in death)	a. Due to (or as a consequ	ence of):	1111	Tarc	tio	4				
	Examiner		Sequentially list conditions	b. Covona	n.	arte	my	dis	Cane	9	15 ho	·un	
2/	ed sit	xaminer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequent	ence of):								
10	xecut	xan	that initiated events resulting in death) Last	c Due to (or as a consequ	ence of):			· · ·		-			
68760	cate be executed physicien and the burial-transit	cal E	(	d									
89 )	certificate be iding physicie ise as the bur	by Physician/Medical	IF FEMALE:										
Вох		sian/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnant 1 Live birth 2 Fetel 4 Pregnant at time of de	death 3	Ectopic pregnar Other (specify)				23d. Date of Month		ear	
P.O.	0 0	nysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 Unknown	a(ii 5 _	Other (specify)							
ď	requires that the een signed by th nould be detache	y P	Part II. Other significant conditions	contributing to death but not resul	ting in the ur	derlying cause	given in Part I.		23e. Did toba	acco use contribi	ute to the cause of de	ath?	
ord	w requires been sign should be		COPP						بالكافر ا	s 2□No 3	Probably 4 U	nknown	
ec	aw S S S S	Completed	()14						24a. Was an autopsy	pric	re autopsy findings a or to completion of ca	vailable use of	
a F	Tage after Tage Peg		25 14						perform 1  Yes 2	XNo 1□	ath? ]Yes 2□ No		
Κ		To Be	25. Was case referred to medical examiner?	Hospital: 1 ☐ Inpatient 2 ☐ E	R/Outpatien	t 3□ DOA C	)ther	of Death C	heck only one		(Casaki)		
o u	ding Phys h. After this funeral di		27. Manner of Death		28b. Time of Injury	28c. In				v injury occurred			
Siol	tending leath. tor: After the funer	catic	Natural 5 Pending investigation  3 Suicide 6 Could not be	n		M 1	□Yes 2□I						
Division of Vital Records,	or At after c Direct in by	Certification:	4 Homicide determined		ne, farm, stre	et, factory, offic	<b>:</b> 0	28f	Location (Stre City or Town,		or Rural Roule Numb	10 <i>r</i> ,	
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu		29a. Certifier Pertifying P	nysician: To the best of my know	rledge, death	occurred at the	time, date and	d place, and	d due to the cau	use(s) and mann	er as stated.		
	in 24 i the Fu pletely	Medical	(Check only Z Medical Exa	niner: On the basis of examination and manner stated.	on and/or inv	estigation, in m	y opinion, deal	th occurred	at the time, dat	te and place, and	d due to the cause(s)		
	2 € 9 E	Σ	29b. Signature and title of sertifier			29c. Lice	nse number	Mari	Ilano 29	d. Date signed (I	Month, Day, Year)		

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND TTEM#16a, b. 20a-ck22, perFH, C861, 11/3/06, WS State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Dav Year Ange 2 N. Smith 10 1:34 PMM 25 2006 /Medical Bb. City, Town, or Local III.

If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)

July 29, 19 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Richery Hospice Soseph 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months 1 ☐ M 2 🛱 F Yrs. 213-70-2319 44 Director 1962 Mary Land Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f ahow the Mudical Exaction must be outlined at 1√ Yes 2 No Directo MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21218 USA 810 Cator Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 XNever Married 2 Married 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 \*natural', or 1 ☐ Yes 2 No ģ Specify: Specify: black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) unk 16b. Kind of Business/Industry of Health and Mental Hygiene.

If Item 27 is marked other than or other traumatic avant, the Market or other traumatic avant, the Market or other traumatic avant. College (1-4or 5+) Elementary/Secondary (0-12) Custodian University Of Mtl. Hospital 11 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be filt Department of Health and Mental Hy Important: if Item 27 is marked oth any linjury or other traumatic avant ones. 18. Mother's Name (First, Middle, Maiden Sumame) Be William J. Smith Beatrice Blake ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Betty Campbell/sister 3142 Wilkens Avenue Baltimore, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 3 ☐ Donation GreenMount Crematory 11/2/2006 Balto. Md. State North Ave. Balto. Mi. 21216 21. Signature of Euneral Service enn Part 1. Softer the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician - Endstores AIDS /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, I ary leading to in modale cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Attanding Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Completed by Physician/Medical IF FEMALE: 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Vinknown 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 10 NO 3 Probably 4 Unknown 1 ☐ Yes 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate 1 Yes 25 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one 1 Yes 2 No Hospital: 1 | Inpatient | 2 | ER/Outpatient | 3 | DOA Other: 4 Nursing Home 5 Residence ٩ 6 Other (Specify) this : After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) Medical Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident actor: by the 6 Could not be determined 3 Suicide Diract in by t 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) To the Hospital or A within 24 hours after To the Funeral Dirac completely filled in by 4 | Homicide Cartifying Physician: To me best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) Dister DOG 58214 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BACTICIORE 14D 21217 425 606700 32 Registrar's Signature 31. Date filed (Month, Day, Year) State NOV 0 1 2006 Registrar

0)0/38/01

Sinit

State of Maryland / Department of Health and Mental Hygien@ [] [] [ Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 28,2006 3:45 aM OCT. STOKES VIVIAN ALICE /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner n/A 1020 E.33RD STREET APT.101 BALTIMORE If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Year 84 216 30 6115 5,1922 VIRĞINIA Director Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f ahov tra Medical Examinar must be notified at 1 XYes 2 No BALTIMORE N/A Director MD. 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code APT. 101 21218 USA 1020 E. 33RD ST. by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No ff Yes, Give Year or Dates: 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Maritaf Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: BLACK Specify 3√ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a, Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Coffege (1-4or 5+) Elementary/Secondary (0-12) BALTIMORE CITY CUSTODIAN 11TH and Mental Hygie 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be flik Department of Health and Mental Hy Important: If Item 27 Is marked oth any injury or other traumatic avent Be IRENE STREAT PRESTON WINKLER ျှ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3109 RAVENWOOD AVE. BALTO, MD. CURTIS STOKES (SON) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) NOV.4,2006 PARKWOOD CEMETERY BALTIMORE, MD. Signature of Funeral Service Licenses 22. Name and Address of Facility CALVIN B. SCRUGGS FUNERAL HOME Emadere 23a. Part1. Enter the disease, or complications that cadsed/fine death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. PRESTON ST. BALTO, MD. 21213 Approximate Interval Between Onset and Death fmmediate Cause (Final disease or condition resulting in death) estue Heart on 40915 Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed use es the burial-transit signed by the attending physicien and d be detached for use es the burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes → No 3 ☐ Probably 4 ☐ Unknown page 2 should been 24a. Was an Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No has autopsy perform this certificate 1☐ Yes 31 No ours after death. neral Diractor: After this certifica filled in by the funeral director, I 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 No Other: 4 Nursing Home 5 Tesidence 6 Other (Specify) 2 ER/Outpatient 3 DOA Certification: To 1 Tes 27. Manner of Death 28a. Date of fnjury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide 24 hours a Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medicai 29a. Certifier (Check only one) and manner stated. within 2. 29d. Date signed (Month, Day, Year) 29b. Signature and titte of certifier 29c. License number 2 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 15) chard Bult Mal 21211 Talls )19 m m 31. Date filed (Month, Day, Year) Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

NOV 0 1 2006

				1 - For State Registrar		State o	f Ma	rylar		artmer rtificat				lental Hy	giene Reg. Ne	20	06	3471	6
		Dhysisi	-	Decedent's Name (First, A	fiddle, Las	t)								2. Date of De	ath Da	av	Year	3. Time of Death	1
4		Physici /Medi		Evelyn Marie										Octobe	r 29	, 20	06	11:17 A	М
		Examir	ner	4a. Facility Name (If not insti	-								on of Death	4c. County of Death					
				Upper Chesape  5. Social Security Number	ake M				last birthday)		Air		der 24 Hrs.	8 Date of Bir		arfo		lace (State or Fore	
	н	Funeral Director		167-05-3145		M_2 <b>√_2</b> M_€	r.gc	90	Yrs.	Months		Hou		8. Date of Bir (Month, Da June 2	y, Year	916	Coun	isylvania	-
				Usual Residence of Deceder										ounc 2	., .	3.0	1 (111	iby i varii a	
		arylar bhow	_	10a. State 10b. Co				_	y, Town or Lo	ocation							1	0d. Inside City Lim	
		88-f	Director		ford			J.	oppa									1 ☐ Yes 2 <b>/</b> ☐	NO
		with I	吉	10e. Street and Number 421 Gilmor Ro	he						p Code 21085	=			_	itizen of V $S.A.$	Vhat Coun	try?	
		vurs after death with the Manylan  el', or Iteme 23a or 28a-f ehow Exeminar must be notified at	Funeral	11. Marital Status	uu T	12. Was Dec	edent F	ver in U	S 13				Origin? (Sp	ecify Yes or No			- Americ	an Indian	
	(0	fler d	E	1 Never Married 2	Married	Armed Fo	rces?		1					ecify Yes or No Rican, etc.)			k, White,		
1	93	rel', o	1 by	3€Widowed 4 □ Divo	rced	If Yes, Gr Year or D	ve ates:			1 🗌 Yes	XX No	Spec	eify:			Specify	Whi	.te	
_	5-0	within 72 hours after death with the Maryland sne. than "nature!, or Iteme 23a or 28a-f show ha Medical Exeminat he politied at	Completed	15. Dec (Specify only h	edent's Ed				16a. Dece	kind of wo	ork done	during n	nost of work	ing	16b. h	Kind of Bu	siness/Inc	lustry	
	121	within ane then	dm	Elementary/Secondary (0-	12)	College (	1-4or 5-	-)		DO NOT i	ise retire	id)			_		_		
	d 2	filed Hygie Sther	ပို	12 17. Father's Name (First, Mic	idle, Last)				Clerk			18. Mo	other's Name	e (First, Middle				ity Adm.	
90	an	should be nd Mental marked o	To Be	George T. Kre										es Verca			,		
1	Maryland 21215-0036	shou and M mar umat	-	19a. Informant's Name/Rela	i. in	ype, Print)			19b. Mailin	ng Addres				al Route Numb			State, Zip	Code)	
62	Z	and 2 salth a n 27 ls		John W. Sale	(Son)				421 (	Gilmo	r Ro	oad,	Joppa	, Mary	Land	2108	35		
(	ore	of He		20a. Method of Disposition	ion 3 🗍	Removal from	State	20b. F	Place of Dispo emetery, crei	sition (Na natory or	me of other pla	ce)		Date	20c. L	ocation -	City or To	wn, State	
10	Ë	Pag ment tant:		4 Donation 5 Other (Specify) Moreland Mem. Park 11/0													aryland		
	Baltimore,	permit. Pages 1 and 2 should be filed within 72 hc Department of Health and Mental Hygiene Important: If Item 27 is marked other then "natur any Injury or other traumatic event, Ins Middeal ance.	5	21. Suprature of Foundation	vice Licens	S00			22	2. Name a	nd Addre Br	ess of Ea	zinski	Funera	al H	ome,	P.A.		
		40340		23a Part1 Enter the diseas	0.00000	ligations that s	aucad i	the deat		140/	<u>Οτα</u>	<u> Easi</u>	tern A	venue,	Ess	ex, 1	Maryl	<u>and 2122</u>	1
_		5		shock, or heart failure. Immediate Cause (Final	List only	one cause on e	ach line	€.							11650,			Approximate Interval Between Onset and Death	
-	1	Physician /Medical		disease or condition resulting in death)	-	a. Due to		CONSEC	uence of):	uer	47	25/	TYPE	7_					
		Examiner	Ĺ.				(0. 00 0	0011004	337.33 3.7.										
		D #	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	•	b. Dua to	(or as a	บบกระบุ	uance of).										
	V	ate be executed hysician and the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	1	C. Due to	/												
-	8760,	be ex ician burial	al E	,		Due to	(Urasa	conseq	uence of):										
7 /	687		dlcal			d													
69	Box (	The law requires that the death certific tale has been signed by the attending page 2 should be detached for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnan	.	23c. If yes, out										23d. Date	e of delive	rv	
Do	m.	death e atte	lcla	in the past 12 months?		1 Live b	ant at t			Ectopic p Other (s)		у				Mor		Day Year	
20	P.O.	that the de ed by the detached	hys	9 Unknown		9□ Unkn									-				
Õ	S,	es tha igned be de	by	Part II. Other significant cor		entributing to d					_							e cause of death?	
W80	ord	w requir been si should	Completed by	CIPORIC O	00)/				to A		3672			1 🗆	Yes 2	HANO	3 Proba	ably 4 Unknow	wn
4	Sec.	ie law has b je 2 sl	dr.	MUATINFA	RCI	y	CM	107	V/A					24a. Was auto	osy	p	rior to con	sy findings availal	ole of
_	a F	t: The												1 ☐ Yes	2 DN		eath?	2 □ No	
7	V:E	sician: Th certificate rector, pag	Be	25. Was case referred to me examiner?		Hospital:				A .	_   0#	200		h Check only o	100				_
Ve	of	Attending Physician: The r death. sctor: After this certificate his y the funeral director, page	2	1 Yes 2 No 27. Manner of Death	_	28a. Date (Mon	Inpatien of Injury		ER/Outpatier 28b. Time of		28c. Injur Wor	*		ome 5 Resi				)	
للا	ion		atlor	1 ØNatural 5 ☐ Pe 2 ☐ Accident in	ending restigation		th, Day	Year)	Injury	м		rk? ]Yes 2	□No			•			
Sale, Evelyn	Division of Vital Records,	or Attend after death Director:	Certification;	3 ☐ Suicide 6 ☐ Co	ould not be termined	286. Place	of Inju	y - At h	ome, farm, str	eet, factor	y, office			28f. Location ( City or To			er or Rura	Route Number,	
Sa	۵	rs after rs after ral Directed in by	Cer			Buildi	g, 0.0.	(Spoon						Ony 01 70	uri, Olah	<b>-</b>			
•		To he Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	edical	(Check only 2 Med	ifying Phy ical Exam	reicien: To the	asis of	my kni examina	wladge deal	h accurred vestigation	l at the tir	ms date	and place death occur	and due to the red at the time,	date an	) and ma d place, a	nner as st	ited. the cause(s)	
		he thin 2	Med	one) 29b. Signature and title of ce		and man	ner stat	ed.			c. Licens								
		To To To To To To To To To To To To To T		Azere	160	1000	22-	R	1111	25	~	70°	_ =		-	-		Day, Year) 7 <i>9. 200</i> 0	-
-1		40		30 Name and address of pe	son who	omnleted carr	sa of do	ath (lto-	232) (Tuna	Print)					1	1 /20		19,2000	
		14		ENARPUL 1	LOLLIV	LKOUS	K	/4/	, 200) (1900)	5. 1	KK.	5	7. 1	BERDE	PU.	MI	2	1001	
		Sta	ate	31. Date filed (Month, Day, )	'ear)	32. F	legistra	's Signa	iture.				, , , ,		( / )	-		7	
		Regist	rar	NUV 0 1	2006	132-0	240 0	Ball .	Magaz	100									

			1 - State of Maryland / Dep	partment of Health and Mertificate of Death	Mental Hygien	711115	34717
	Physici		1. Decedent's Name <i>(First, Middl</i> e, Last)  Charlotte Elizabeth Talkington	1	Oct 29,	2006 Year	3. Time of Death  22:03 M
, so	/Medic Examin	_	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	1 4	4c. County of Death	1
	Funeral	2	Southern Maryland Hospital  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	Clinton  or of Under 1 Year of Under 24 Hrs.	8. Date of Birth	Prince Ge	place (State or Foreign
	Director		579 26 4963 1 M 2 F 80 Yrs.  Usual Residence of Decedent	Months Days Hours Min.	Sept 7, 1	1926 Mar	yland
	how		10a. State 10b. County 10c. City, Town or L	ocation			10d. Inside City Limits
	the Ma 28a-f s	recto	Maryland Prince George's Clinton  10e, Street and Number	10f. Zip Code	10g. C	Citizen of What Cou	1 ☐ Yes No
	23a or	al Di	9009 O'Riley Drive	20735		United Sta	=
396	urs after dea al', or Itame examinar m	by Funeral Director	11. Marital Status  1 Never Married A Married  3 Widowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 Yes, Give Year or Dates:	. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☐ No Specify:	pecify Yes or No- o Rican, etc.)	14. Race - Ameri Black, White, Specify: Wh:	
Maryland 21215-0036	permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other then "natural", or Itame 23a or 28a-f show any injury or other traumatic event, the Modical Exemples must be notified at ADDE.	Completed	15 Decedent's Education 16a Dece	edent's Usual Occupation e kind of work done during most of won DO NOT use retired)	king	Kind of Business/Ir	
1d 2	Il Hygie other	Be Co	17. Father's Name (First, Middle, Last)		ne (First, Middle, Maide		ng
ylar	ould be t Menta narked natic ev	To E	Harman Brown		a M. Moneyn		-0-11
Ma	alth and 27 is a			ling Address (Street and Number or Ru O ORiley Drive, Cla			
Baltimore,	Pages 1 e		1 □ Donation 5 □ Other (Specify) Parklawn	ematory or other place) n Cemetery Nov 1, 2	2006 Ro	Location - City or Tockville,	Maryland
Balt	permit. Departi Import. any inj		1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	22. Name and Address of Facility Lee Alexandria Ferry Ro			6633 01d 0735
			23a. Part1. Enter the disease, or complications that caused the death. Do not er shock, or heart failure. List only one cause on each line.  Immediate Cause (Final				Approximate Interval Between Onset and Death
, s.	Physician /Medical		disease or condition resulting in death)  a. ACUTE MY 0 ( Due to (or as a consequence of):	CARDIAL INFAR	CTION		
70.	Examiner	er.	Sequentially list conditions, if any, leading to immediate b. Co Ron Ary  Due to (or as a consequence of):	ARTERY DISEA	HE		
۵.	nd ransit	Examiner	cause. Enter Underrying Cause (Disease or injury that initiated events c.				
760,	ate be executed thysicien and the burial-transit	Ical Ex	resulting in death) Last  Due to (or as a consequence of):				
68	ntificate ing phy: a as the	Medic	IF FEMALE:		9		
P.O. Box	Attending Physician: The law requires that the death certificate be executed rideath.  setor: After this certificate has been signed by the attending physicien and by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Med	23b. Was decedent pregnant in the past 12 months?	☐Ectopic pregnancy ☐ Other (specify)		23d. Date of deliv Month	e <b>ry</b> D <b>a</b> y Year
	es that igned b be deta	ρ	Part II. Other significant conditions contributing to death but not resulting in the $BRA_1NTUMOR$	underlying cause given in Part I.		o use contribute to t	
Sord	w requir been si should	leted	HYPERTENSION		1 ☐ Yes	-	bably 4XXJnknown  opsy findings available
Division of Vital Records,	iclan: The lav certificate has rector, page 2	Completed	11 IFERTE WILL		autopsy performed?	prior to co	ompletion of cause of 2 \subseteq No
Vita	iclan: Sertifica ector,	Be	25. Was case referred to medical exampler?  Hospital:	Other	ath (Check only one)		
to	g Phys er this eral dir	n: To	27. Manner of Death 28a. Date of Injury 28b. Time	of 28c. Injury at	ome 5 Residence 28d. Describe how in		fy)
sior	tendin death. tor: Aft the fun	catlo	2 Accident investigation	M 1 ☐ Yes 2 ☐ No	20f Landing (Street		-1.C
Σ	el or Al s after o al Direct	Certification:	4 Homicide determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	treet, factory, office	28f. Location (Street: City or Town, Sta		ai Houte Number,
	To the Hospitel or Attending Physician: The lawithin 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	edical	29a. Certifier (Check only one)  1 **Certifying Physician: To the best of my knowledge, dea 2 **Medical Examiner: On the basis of examination and/or i and manner stated.	ith occurred at the time, date and place investigation, in my opinion, death occu	, and due to the cause irred at the time, date a	(s) and manner as s and place, and due t	stated. to the cause(s)
)	To t To t	×	29b. Signature and title of certifier	29c. License number D#0324		Date signed (Month, TOBER F	
_	4		30. Name and address of person who completed cause of death (Item 23a) (Type TERRY JOBUE, MI) 7503 SURRATI	7.5 ROAD, CLINTO	on, mary	LAND 2	9735
10 M	Sta Regist		31. Date filed (Mon NOV) 2006 32. Registrar's Signature	heils			

			1 For State of Marylan	d / Department of Health and		
	já.		Registrar  1. Decedent's Name (First, Middle, Last)	Certificate of Death	Reg. No.2 U	
	Physic /Medi	cal	RUDOL PH  4a. Facility Name (If not institution, give street and number)	TALBOT	2. Date of Death  Month, Day  October 30, 2	3. Time of Death 2006 4:59 P M
	Exami	ner	BON SECOURS HOSDITAL	4b. City, Town, or Location of Dec	ath 4c. Count	ty of Death
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. I			Birthplace (State or Foreign Country)
	p ,		Usual Residence of Decedent	/, Town or Location	Dec. 21, 1933	
	iges 1 and 2 should be filed within 72 hours after death with the Maryland at Hogiene.  If flem 27 is marked other then "neture!", or Items 23s or 28s-f show or other treumatic event, the Medical Examinar must be notified at	ctor		ALTIMORE		10d. Inside City Limits 1 ☑ Yes 2 ☐ No
	with the or 26	by Funeral Director	10e. Street and Number 5 S. ELLA MONT ST.	10f. Zip Code	10g. Citizen ol	What Country?
	death	nera	11. Marital Status 12. Was Decedent Ever in U.S	S. 13. Was Decedent of Hispanic Origin? ( If Yes, specify Cyban, Mexican, Pue	(Specify Yes or No- 14. Ra	ce - American Indian,
36	s after , or Ite	y Fui	1 Never Married 2 Married 1 Yes 2 No	If Yes, specify Cuban, Mexican, Pue	erto Rican, etc.) Bla	ack, White, etc.
21215-0036	2 hours	ted b	3   widowed 4   Divorced Year or Dates:	16a. Decedent's Usual Occupation		Business/Industry
215	within 73 ene. then "no	Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)	(Give kind of work done during most of will life. DO NOT use retired)	orking 166. Kind of E	susiness/industry
	filed with Hygiene. ther the	Cor	17. Father's Name (First, Middle, Last)	Truck Driver	Ame (First, Middle, Maiden Suma	
Maryland	ould be Mental Marked o	To Be	HORACE TAIBOT	EMMA		me)
Mar	th and the man treem.		19a. Informant's Name/Relationship (Type, Print)  ODESSA WEBB- FRIEND	19b. Mailing Address (Street and Number or F 5 S. ELLA MONT ST.	Balto, MD. 21	, State, Zip Code)
ore,	ss 1 and of Health iftem 27		20a. Method of Disposition 20b. Pl	ace of Disposition (Name of metery, crematory or other place)		- City or Town, State
Baltimore	E E E			ZION CEMETERY 11-	06-06 BAIL	O. MD.
Bal	Depertrimportrim		21. Signature of Funeral Service Licensee	22. Name and Address of Facility Michael Ziglier Fun 3512 Freberick A	SUC PA. NE. BAHO, HD 2	1229
			23a. Part1. Enter the disease, or complications that ceused the death. shock, or heart failure. List only one cause on each line.	Do not enter the mode of dying, such as cardia	ac or respiratory arrest,	Approximate Interval Between
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	cardial Jerfor	ction	Onset and Death
1	Examiner		( 0 0 0 0	y stindileo	le	
7in	uted Insit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	enge ol):		
0,	execuen and irrial-tra			ance of):	, A-	
68760,	ficate be executed physicien and s the burial-transit	edical	Co Monte	Defendent dia	belis	
Вох	eath certific attending p	an/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months 2 ☐ Fetal of 1 ☐ Live birth 2 ☐ Fetal of 1 ☐ Fetal of 1 ☐ Fetal of 1 ☐ Fetal of 1 ☐ Fetal of 1 ☐ Fetal of 1 ☐ Fetal of 1 ☐ Fetal of 1 ☐ Fetal of 1 ☐ Fetal of 1 ☐ Fetal of 1 ☐ Fetal of 1 ☐ Fetal of 1 ☐ Fetal of 1 ☐ Fetal of 1 ☐ Fetal of 1 ☐ Fetal of		23d. Da	te ol delivery
o.	The law requires that the death certificate be executed the has been signed by the attending physicien and hage 2 should be detached for use as the burial-transit	Physician/Me	1 ☐ Yes 2 ☐ Mo 9 ☐ Unknown 4 ☐ Pregnant at time of dea		Mo	onth Day Year
ds, P	ires tha signed I be det	þ	Part II. Other significant conditions contributing to death but not result	ting in the underlying cause given in Part I.		inbute to the cause of death?
COL	aw requir is been si 2 should	oletec	Company (Control)	hu buy	1  Yes 2  No	
Vital Records,		Completed			autopsy performed?	Were autopsy lindings available prior to completion of cause of death?  ↑ ☑ Yes 2 ☑ No
	S S S	o Be	25. Was case referred to pedical examiner?    Hospital:   Impatient   25.	Other	ath (Check only one)	
		$\vdash$	and the second s	POutpatient 3 DOA Uner: 4 Nursing F	Home 5 Residence 6 Oth 28d. Describe how injury occurr	
Division	ten tor: the	icatio	2 Accident investigation	M 1 Yes 2 No		
ź	호텔등	Certification:	4 Homicide determined 288. Place of Injury - At nomburilding, etc. (Specify)	e, farm, street, lactory, office	28l. Location (Street and Numb City or Town, State)	er or Rural Route Number,
	To the Hospital or At within 24 hours after of To the Funeral Directompletely filled in by	edical	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my know 2 Medical Examiner: On the basis of examination and manner stated.	odge death occurred at the time, date and place in and/or investigation, in my opinion, death occu	e, and due to the cause(s) and ma urred at the time, date and place, a	and due to the cause(s)
	To t To t	Σ	29b. Signature and title of certifier	MD 29c. License number		1 (Month, Day, Year)
•	2	1	30. Name and address of person the completed cause of death (Item 2	23a) (Type, Print)	104	31-06
			2000 Wast Bollino	of Street MV:	21223,	
	Sta Registr		31. Date liled (Marry Day, Year) 2006 32 Registrar's Signatu	Locale		

		1 - For State Registrar	State of Marylan		artment rtificate			nd Mer		jiene leg. No.	006	34	719
Physici /Medi	al	Decedent's Name (First, Middle, Las     Ralph H. Twining      Aa. Facility Name (If not institution, give			4h City	Town or	Location of		Date of Dea Month	Day	Year 6,2006 county of Deat		
Examir Funeral Director	ier	Charlesto 5. Social Security Number 6. S.	ex 7. Age (In yrs.	last birthday) Yrs.	If Under Months	20	If Under 24	4 Hrs. 8.	Date of Birth (Month, Day	, Year)	9. Birt	MOTO hplace (State untry)	or Foreign
pu .	tor	Usual Residence of Decedent  10a. State 10b. County  MD Baltimo		y, Town or Lo	ocation usvill	e		J	uly 22	<b>2,</b> 19	20 Mi	chigan  10d. Inside (	
th with the 23s or 28s	al Director	10e. Street and Number 709 Maiden Choic	e Lane RGS 128		10f. Zip		21228		1	10g. Citize	on of What Co	untry?	
ours after dea	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	1	Was Deced If Yes, spec 1 ☐ Yes 2		spanic Origin, Mexican, Specify:	in? (Specify Puerto Rica	Yes or No- an, etc.)		Race - Ame Black, White Specify: Wh	e, etc.	
perillingter, Invary fatting Z.I.Z.13-0030 permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: if Item 27 is marked other then "naturel", or Items 23e or 28e-f show says injury or other traumatic event, the Madical Excitorational Landing at ance.	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12) 1 2		(Give	dent's Usua kind of wor DO NOT us	k done di e retired)	tion uring most o	of working			of Business/		
rylatio	To Be C	17. Father's Name (First, Middle, Last) Ralph Hubert Twin 19a. Informant's Name/Relationship (i		10b Mailie	a Addrasa		01iv	e Dec			umame) Town, State, 2	Pin Codal	
Te, Inc		Sybil Wanberg/s	sister 20b.P	3729	E. 30	Oth I	Place	tulsa Date	, OK	7111			
Dartillor permit. Pages Department of Important: If it eny injury or o		1 Burial 2 Cremation 3 4 Donation 5 Other (Specification Signature of Funeral Service Licen RO nated S.	()	emetery, crer				pard 6	55 W	Ra1+	imore	Stroot	
		23a. Part 1. Enter the disease, or compshock, or heart failure. List only	plications that caused the death	Be	altimo	ore,	MD 2	21201			inore	Approxima Interval Be Onset and	ate etween
Physician /Medical Examiner		disease or condition resulting in death)	Due to (or as a consequence of the consequence of t	Kins	onig		)ise	ase	2				
ate be executed sysicien and he burial-transit	ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a consequence of the conseq										
The COLUS, T.O. BOX 601000.  The law requires that the death certificate be executed ate has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	23c. If yes, outcome of pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of do 9 □ Unknown	Ideath 3□	Ectopic pro					23	d. Date of deli Month	very Day	Year
w requires that been signed be should be deta	ρ	Part II. Other significant conditions of	ontributing to death but not res	ulting in the u	nderlying ca	ause give	n in Part I.		23e. Did tol		ocontribute to		
OI VICAL INC.C. Physician: The law rathis certificate has be rail director, page 2 sh	Completed							_	24a. Was a autops perform	SV	24b. Were au prior to death? 1 \sum Yes	topsy lindings completion of 2 No	s available cause of
Physician: This certificated director, p.	To Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☐ No.	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatier	* 3□ NO	Otho			heck only on		Other (Spec		
To the Hospital or Attending Physician: The is within 24 hours effer death.  To the Funeral Director: After this certificate ha completely filled in by the funeral director, page?		27. Manner of Death 1 Nateral 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury		Bc. Injury Work		28d.	Describe ho			.ny)	
To the Hospital or Attending within 24 hours eiter death. To the Funers! Director: Affect completely filled in by the fune.	Certifications	3 ☐ Suicide 6 ☐ Could not be determined	building, etc. (Specify	v)					City or Town	n, State)	Number or Ru		n <i>ber</i> ,
the Hosp hin 24 ho the Fund hpletely fi	Medical	(Check only 2 Medical Exam	ysician: To the best of my kno niner: On the basis of examina and manner stated.	wledge, death tion and/or in	vestigation,	in my opi	inion, death	place, and occurred a	it the time, d	ate and p	lace, and due	to the cause	(s)
To To		29b. Signature and title of cedifier	e, MD			License		7			ober		2006
Sta	te	30. Name and address liperson who are so	completed cause of death (Item  2 7 1 M Call  32 Registrar's Signa	den	Cho	ice	La	ne,	Balt	ino	ober re, M	D212	228
Regist		NOV 0 1 20	8	M Ca	25/2								

			1 - For State Registrar	State of Maryland	/ Depa	rtment of Hea	ilth and M ath	ental Hygi	ene 006	34720
	Physici	an	Decedent's Name (First, Middle, Last,		7	7 1		2. Date of Death Month		3. Time of Death
	/Media	al	Cynthia 4a. Facility Name (If not institution, give	Street and number)	'	4b. City, Town, or Loc	nation of Dooth	October	27 2cc	
	Examir	ier	The Johns Hopkil			Baltimon	1 - 1	¥	N/A	Jain
	Funeral		Social Security Number     6. Security Number	7. Age (In yrs. last		If Under 1 Year II I	Under 24 Hrs.	8. Date of Birth (Month, Day,	9.8	lirthplace (State or Foreign Country)
	Director		216 78 5980 Tusual Residence of Decedent	48	Yrs.			SEPT.2	7,1958	MD.
	yland		10a. State 10b. County	10c. City, T	own or Lo	cation				10d. Inside City Limits
	Ba-f el	Director	MD. N/A	В	ALTI	MORE				1 XYes 2 □ No
	with th	Dire	3028 E. FEDERA	T. ST		10f. Zip Code	21213	10	g. Citizen of What ( USA	Country?
	deeth	Funeral		12. Was Decedent Ever in U.S.	13. V	Vas Decedent of Hispar	nic Origin? (Spe	cify Yes or No-		nerican Indian,
36	s 1 and 2 should be filed within 72 hours after deeth with the Maryland I Health and Mental Hygiene. I Health and Mental Hygiene. Item 27 is marked other than "netural", or iteme 23s or 28s-f show other traumatic event, the Medical Experient must be rediffied at	by Fur	1 XNever Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 [X]No If Yes, Give	tr	Yes, specify Cuban, M	lexican, Puerto I pecify:	Rićan, etc.)	Black, Wi	
21215-0036	2 hour	ted t	15. Decedent's Edu		6a. Deced	ent's Usual Occupation		1	6b. Kind of Busines	
215	ithin 7.	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	(Give I	and of work done during OO NOT use retired)	g most of workir	ng		,
2	lied wi Hygien Iher th		12TH  17. Father's Name (First, Middle, Last)	2/-	H	OMEMAKER	Mathada Na		ISABLED	-
Maryland	ouid be filed v Mental Hygie tarked other t tatic event, to	To Be	JOHNNIE JOHNS	ON		18.		(First, Middle, M. IORNTON	aiden Sumame)	
ary	2 should and Men ie marke aumatic	۲	19a. Informant's Name/Relationship (Ty	pe, Print)		Address (Street and I	Number or Rura	Route Number,		, Zip Code)
	1 end 2 Health a em 27 ie		TIERRA THORNTON			44				
altimore,			20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ R	emoval from State	etery, crem	ition (Name of atory or other place)			0c. Location - City o	
Ħ.	permit. Page Depertment of Importent: if eny injury or once.		4 ☐ Donation 5 ☐ Other (Specify)  21. September of Funeral Service License			OF FAITH Name and Address of				
Ö	Ped Fire and and and and and and and and and and		Memadine o	Acrusol	1	Name and Address of CALVIN B.	SCRUG ESTON	GS FUN	ERAL HON	ME 21213
			23a. Part1. Enter the disease, or compli shock, or heart lailure. List only or	cations that caused the death. I	o not ente	r the mode of dying, su	ich as cardiac oi	respiratory arres	it,	Approximate Interval Between
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Decompensa		Heart	Failu	re		Onset and Death
	Examiner			Due to (or as a consequent	ce of):	Dehisce	nce			2 weeks
	D =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequen-		Derri sec				7 35 (3)
/	ecute and I-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	. Due to (or as a consequent	ce of):					
8760,	cate be executed obysicien and the burial-transit	dlcal E	L.	240 (0) (0) 40 4 00/100440/1	00 017.					
89	rtificat ng phy as th	Medi	IF FEMALE:							
Вох	eath certifi ettending for use as	lan/	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregnancy 1□Live birth 2□Fetal de	ath 3 □	Ectopic pregnancy			23d. Date of d	elivery Day Year
o.	the de y the e	ysic	1 ☐ Yes 2 ☐ 10 9 ☐ Unknown	4☐Pregnant at time of death 9☐ Unknown	5 □	Other (specify)				July 134
o,	law requires that the death certificate been signed by the ettending (	by Physician/Me	Part II. Other significant conditions con	tributing to death but not resultin	g in the un	derlying cause given in	Part I.	23e. Did toba	cco use contribute	to the cause of death?
ord	w require been si should b	ted						1 🗆 Yes	2 <b>©</b> No 3 □ F	Probably 4 Unknown
Records,	e - e	Completed						24a. Was an autopsy performe	prior to	autopsy findings available completion of cause of
_	sician: Th certificate rector, pag	င္ပ	25. Was case referred to medical			28	Disease Dooth			s 2 No
ot <	\$ .2 5	ToB	examiner?	ospital: 1 ☐ Impatient 2 ☐ ERV	Outpatient	O+			ce 6 □Other (Sp	ecify)
0 0	5 9 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		27. Manner of Death 1 → Matural 5 → Pending	28a. Date of Injury (Month, Day Year)	b. Time of Injury	28c. Injury at Work?	2	8d. Describe how		
Division	Attending r death. ector: After by the fune	flcat	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At home	larm stre	M 1 ☐ Yes		8f Location (Stre	et and Number or F	Rural Route Number.
á	7 3 7 5	Certification;	4 Homicide	building, etc. (Specify)		.,,		City or Town,	State)	
	To the Hospital of within 24 hours at To the Funerel D completely filled in	edical	29a. Certifier 1 Certifying Phys (Check only one) 2 Madical Examir	ician: To the best of my knowled ar: On the basis of examination	dge, death and/or inve	occurred at the time, da estigation, in my opinior	ate and place, at	nd due to the cau d at the time, date	se(s) and manner a	as stated.
	othe vithin 2 o the omple	Med	29b. Signature and title of certifier	and manner stated.		29c. License nun			I. Date signed (Mor	
)	F > F 0		1 Delon	niel Munoz, Media	الم الم	RES -	000			17, 2006
	3	j	30. Name and address of person who co			10.		1 0 11	N M	1 1 2 3
	Sta	10	Vaniel Munaz The 31. Date filed (Month, Day Year) 2006	Johns Hopkins Ho	spital	600 po.76	Walte St	neet, tall	mae Ma	ryland 21287
	Registr	ar	NUV 0 1 2006	37 Registrar's Signature	Ans	Per)				

		•	1 - State Registrar	State of Mary		partment of ertificate				giene Reg. No.	2006	34721
	Physici		1. Decedent's Name (First, Middle, La	st)  Bonnie Do	rene Wr	-iaht			Month	Day	Year 2006	3. Time of Death
	/Medic Examin		4a. Fecility Name (If not institution, giv		Telle Wi		wn, or Location		700000	-	County of Deel	
1	E.Adiiiii	Ϋ.	Friends House Nu	rsing Home		Olne	У			Mo	ontgome	ry
	Funeral		5. Social Security Number 6. S	Sex 7. Age (In	yrs. last birthd	Months D	ear If Unde	Min.	. Date of Birt (Month, Da	y, Year)	Co	thplace (State or Foreign buntry)
ш	Director		219-68-2567	86	Yrs			] [	Jan 11	, 19:	20 Vir	ginia
	and w		Usual Residence of Decedent  10a. State 10b. County	10	c. City, Town o	r Location						10d. Inside City Limits
	f aho	ត្ត	MD Montgom	ery F	Burtons	71110						1 ∑Yes 2 □ No
	the routil	rec	10e. Street and Number	iery i	our comb	10f. Zip Co	de			10g. Citiz	zen of What Co	ountry?
	h with	a D	3737 Bell Road			2086	6			U.S	.A.	
	deat ms 2	Funeral Director	11. Marital Status	12. Was Decedent Ever Armed Forces?	r in U.S.	13. Was Deceden	t of Hispanic O Cuban, Mexica	origin? (Speci an. Puerto Ri	fy Yes or No-	- 1	14. Race - Ame Black, Whit	
36	ges 1 and 2 should be filed within 72 hours atter death with the Maryland to Haalih and Menial Hygiene. If Item 27 is marked other than "naturel", or Items 23a or 28a-f ahow or other treumatic event, II:a Medical Esonia ar must be notified at	by Fu	1 Never Married 2 Married 3 ☑ Widowed 4 Divorced	1 Yes 2 No If Yes, Give Year or Dates:		1 ☐ Yes 2 🛭			,		Specify: Whi	
8	turel	edt	15. Decedent's E		16a. De	ecedent's Usual C	ccupation			16b, Kir	nd of Business	
21215-0036	on no	Completed	(Specify only highest grant (0-12)	ade completed)  College (1-4or 5+)	(G	ive kind of work of e. DO NOT use i	fone during mo etired)	ost of working	'			
212	d with	E	10		Home	emaker				Own	Home	
nd	I be filed withir ntal Hygiene. ad other than event, tra M	Be (	17. Father's Name (First, Middle, Last	)				her's Name (		Maiden	Sumame)	
Maryland	Meni de la marka	၉	Kenneth DePew					a Ann				
Jar	l 2 sh and n and l		19a. Informant's Name/Relationship ( Sandra S. Wright	**		ailing Address (S				-		Zip Code)
	1 and Haaltl em 27 ther 1	1	20a. Method of Disposition		Ob. Place of D	isposition (Name	of	Dat COITS	-		cation - City or	Town, State
nor	Pages nent of I ant: If Ite		1 XBurial 2 ☐ Cremation 3 ☐ '4 ☐ Donation 5 ☐ Other (Speci			crematory`or othe Cemetery		Oct 27	7, 06	Bur	tonsvil	le, MD
Baltimore,	permit. Pages 1 and 2 should be f Department of Haelih and Mental i Important: if Item 27 is marked of eny linjury or other freumatic eve eny linjury or other freumatic eve		21. Signal in of Funeral Service Lice			22. Name and A Donalds					land 20	707-4389
			23a. Part1. Enter the disease, or conshock, or head lajure. List only	plications that caused the	death. Do not						Iuna 20	Approximate
	Physician		Immediate Cause (Firal	one cause on each line.  Myocardia								Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	Due to (or as a co								
	Examiner		Sequentially list conditions,	b								
	B 4 5	lner	cause. Enter Underlying Cause (Disease or injury	Due to (or as a co	onsequence of)							
	and and tran	Examin	that initiated events resulting in death) Last	c.  Due to (or as a co	onsequence of):				-			
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89	g phy as the	edic		V								
Вох	eath certific attending p	M/W	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of p 1☐Live birth 2 ☐		3 □Ectopic pregi	nancv			2	23d. Date of de	/
O. B	The law requires that the death certifi tie has been signed by the attending tage 2 should be detached for use as	Physician/Me	in the past 12 months? 1 ☐ Yes 2 XNo 9 ☐ Unknown	4☐Pregnant at tim 9☐ Unknown		5 Other (speci	fy)				Month	Day Year
Ω.	res that the de signed by the a be detached f	Ph)	Part II. Other significant conditions	contributing to death but n	ot resulting in th	ne underlying caus	se given in Pari	t I.	23e. Did to	obacco u	se contribute to	the cause of death?
Records,	n sign	d by							10	Yes 2[	□No 3□Pi	robably 4 🖔 Unknown
000	s been si s should	Completed							24a. Was		24b. Were au	utopsy findings available completion of cause of
Re	sician: The law certificate has t ifector, page 2 s	E							perfo	med?	death?	2X No
Vital		Be C	25. Was case referred to medical examiner?				26. Pla	ce of Death (				
of V	> 0	To	1 ☐ Yes 2 🔀 No	Hospital: 1 Inpatient	2 ER/Outpa	atient 3 DOA					6 □Other (Spe	cify)
ū		on:	27. Manner of Death 1   Natural 5 □ Pending	28a. Date of Injury (Month, Day Ye	ear) 28b. Tim Inju		Injury at Work?		ld. Describe l	now injur	y occurred	
Sio	Attending in death.	cati	2 Accident investigation 3 Suicide 6 Could not l	De Class of Injune	At home form	M street featen	1 Yes 2		of Location /	Street an	d Number or Ri	ural Route Number,
Division	atter of Direct of in by	Certification:	4 ☐ Homicide determined	28e. Place of Injury building, etc. (5	Specify)	, street, ractory, o	ilice	20	City or Tox	vn, State	)	arai riodio ridinodi,
	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical C		hysician: To the best of miner: On the basis of example and manner stated	amination and/o							
	To the within 2 To the comple	Me	29b. Signature and title of certifier			29c. L	icense number	r		29d. Dat	e signed (Mont	th, Day, Year)
			Cluston	arpus		D3	9793		(	Octol	ber 24,	2006
	17		30. Name and address of person who	completed cause of death	n (Item 23a) (Ty	pe, Print)						
_			Christopher J. M		18111 P	rince Ph	ilip Dr	c. Olne	ey, Ma	rylaı	nd 2083	2
	Sta Regist		31. Date filed (Month, Day, Year)  NOV 0 1	32. Registrar's	Signature	poels						

State of Maryland / Department of Health and Mental Hygien 2006 34722 1 - For State Registrar Certificate of Death 1 Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death October 28, 2006 Physician Melvin H. Weinberger 6:50 A. M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Quail Run Assisted Living Baltimore Parkville If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. April 10, Birthplace (State or Foreign Country)
 Mary land 5. Social Security Number 6. Sex 1 M M 2 ☐ F 7. Age (In yrs. last birthday) **Funeral** 1916 90 213-07-9997 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Itam 27 is marked other than "natural" ~-" say hiury or other traumatic average. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits **Baltimore** Maryland Baltimore 1 Yes 2 No Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2731 Waldor Drive 21234 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: White þ 3 ☑ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Steam Fitter Steam Fitter's Union 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Albert Weinberger Suzanna Keller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shirley Disney/Daughter 2731 Waldor Drive Baltimore Maryland 21234 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Moreland Memorial Park 11/2/06 Baltimore Marvland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Leonard J. Ruck Inc. 5305 Harford Road Baltimore Maryland 21214 21. Signature of Funeral Service Licenses lton hustina 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Jonary /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last monie 065 True Due to (or as a consequence of): Examiner physicien and s the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physiclan/Medical 88 led by the attending detached for use as 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown been signed by t should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ 3 ☐ Probably 4 ☐ Unknown 1 Yes 2 □ No Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed? Yes 2000No has page 2 1 ☐ Yes funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 455-54 2 No ဥ 1 🗌 Yes 2 ER/Outpatient 3□ DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred After Injury 5 Pending 1 ☐ Yes 2 ☐ No Director: A 2 Accident investigation 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours at To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier ical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) lle 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sallie Rixey 1
31. Date filed (Month, Day, Year) Drue Baltmare Hd 21237 9101 32. Registrar's Signature MO

DHMH 17 Rev 1/2001

State

Registrar

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2006

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEDN TTPM/18, perFH C861, 11/1/06, WS State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** 10:00 AM M 26, 2006 October /Medical Robert Luther Wanzer
4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Randolph Hills Nursing Center Silver Spring Montgomery Date of Birth (Month, Day, Year) Age (In yrs. last birthday) If Under 1 Year Birthplace (State or Foreign Country) Funeral Months Days Hours 1**2** M 2 □ F Director 86 03/19/1920 579-07-3607 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show ral", or items 23a or 28a-f shore Examiner must be notified at 1 ☐ Yes 2 No Director Silver Spring Montgomery MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4011 Randolph Road
11. Marital Status USA 20902-Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Yes 2 ☐
If Yes, Give
Year or Dates: 1 ☐ Never Married 2 Married Specify: Black 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced "natural" al Hygiene. I other than "natura event, the Medical E 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Private Elementary/Secondary (0-12) College (1-4or 5+) Cab Driver alth and Mental Hyging 27 is marked other raumatic event, the 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be CARTER Fannie (Unavailable ၉ Luther Wanzer 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health 7620 Maple Ave #240 Takoma Park, MD 20912-Jeannette P. Wanzer/Wife other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Department of H Important: If Ite any Injury or ot once. 1 ☐ Burial 2 Macremation 3 ☐ Removal from State Oct 28 Beltsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2006 Chesapeake Crematory 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 1100382 Rapp Funeral & Cremation Services 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximately a such as cardiac or respiratory arrest,

Approximately a such as cardiac or respiratory arrest,

Approximately a such as cardiac or respiratory arrest,

Approximately a such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Ceuse (Final Alzheimer's Disease Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? ō Day Year 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by Coronary Artery Disease 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 2 **N**o director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ၉ 1 TYes 28a. Date of Injury (Month, Day ) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Year) 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. (Check only one)

Examiner The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, physician ending p been signed by the a should be detached f s certificate has be irector, page 2 s To the Hospital or Attending Physician: this neral Director: / within 24 hours a

To the Funeral C

completely filled i

the Maryland

death

Pages 1 and 2 should be filed within 72 hours after

Baltimore, Maryland 21215-0036

State

29b. Signature and title of certifier

31. Date filed (Marth

Alan R. Segal 1517 32 Registrar's Signature

30. Name end address of person who completed cause of death (Item 23a) (Type, Print)

Hugo Circle Silver Spring MD 20906

29c. License number

D52261

29d. Date signed (Month, Day, Year)

10-26-2006

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 28, 2006 1:08A Oct. Mackenzie Walser 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Gilchrist Center Hospice
5. Social Security Number | 6. Sex/ | 17 Age /in ure Towson If Under 1 Year Baltimore If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 09/19/1924 Birthplace (State or Foreign Country) last birthday Days Months Min Hours 1⊠M 2□F 047.18.1446 82 ŃΥ Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Lutherville-Timonium MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21093 U.S.A. 8 Inverin Circle 14. Bace - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. Armed Forces:

1 X Yes 2 No
If Yes, Give
Year or Dates: 1942 - 45 1 ☐ Never Married Married 1 ☐ Yes 2 ☐ No Specify. White Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15, Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Hopkins Research Physician 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Kenneth Walser Jean Mackenzie 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21093 19a. Informant's Name/Relationship (Type. Print) Inverin Circle Luterville-Timonium.MD Betsy A. Walser/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee MO1443 di Cremation And Funeral Alternatives 21286 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate
Interval Between
Onset and Death
Months Immediate Cause (Final disease or condition resulting in death) homa Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome pf pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9∏ Linknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Strokes 2 No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 No 1 ☐ Yes 1 🔲 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending investigation

/Medical Examiner attending physician and for use as the burial-transit requires that the death certificate be execu n signed by the s Id be detached f

Box 68760,

P.0.

Division or Vital Records,

**Physician** 

/Medical

Examiner

**Funeral** 

Director

"natural", or items 23a or 28a-f show adical Examiner must be notified at

Medical

the

Department of Health a Important: If item 27 is any injury or other trat

**Physician** 

Director

Funeral

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Certification:

Medical

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f show

Baltimore, Maryland 21215-0036

page 2 should certificate has After this funeral

completely filled in by the

To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After

1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

N. Charles St. Balto M& 2120x

Registrar

31. Date filed (Month, Day, 2006

BIAL 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 10:00 PM /Medical Ann T. Whims
4a. Facility Name (If not institution, give street and number) 29 2006 4c. County of Death October 4b. City, Town, or Location of Death Examiner Gilchrist Center for Hospice Care
5. Social Security Number 6. Sex J 7. Age (In vrs. last hirth TOWSON
| FUNDER 24 Hrs. | 8. Date of Birth (Month, Day, Year) Baltimore
9. Birthplace (State or Foreign Country) If Under 1 Year **Funeral** Days 1 □ M 2 □ F Director 07/02/1935 VA 10c. City, Town or Location 10d. Inside City Limits the Maryland 10b. County 10a, State item 27 is marked other than "natural", or items 23a or 28a-f shov other traumatic event, the Medical Exa<u>miner must be notified at</u> 14 Yes 2 No Director Baltimore | 10f. Zip Code Baltimore City 10g. Citizen of What Country? 10e. Street and Number death with Funeral 21218

13. Was Decedent of Hispanic Origin? (Specify Yes or NoIf Yes, specify Cuban, Mexican, Puerto Rican, etc.) USA 14. Race - American Indian, 415 Southway 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. e filed within 72 hours after oal Hygiene. I bygiene. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Completed by 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Private Sector Elementary/Secondary (0-12) Chef 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be and 2 should be ဥ William Shelburn Thomas Mary Juanita 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) if Health William Burch/Husband 415 Southway Baltimore, MD 21218 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Oct 31 4 Donation 5 Dother (Specify) Beltsville, Maryland Chesapeake Crematory
22. Name and Address of Facility 2006 21. Signature of Funeral Service Licensee Cremation and Funeral Alternatives 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Maryland Approximate Interval Between Onset and Death Immediate Cause (Final NeasI read **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine attending physician and for use as the burial-transi Due to (or as a consequence of): The law requires that the death certificate be exec Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month in the past 12 months? 1 ☐ Yes 2 ☐ No Day 5 ☐ Other (specify) 4□Pregnant at time of death signed by the a d be detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 1 Tyes 3 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an performe med2 2 No certificate To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA မ 28b. Time of Injury 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: Director: After 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated.

within 24 hours a

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BMC

32. Registrar's Signature

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21215-0036

Maryland

altimore.

Registrar DHMH 17 Rev 1/2001

State

6701

29c. License number

D25205

N. Charles Str Balts, MIZIZOG

29d. Date signed (Month, Day, Year)

		For State Registrer	State of Mai	ryland /		artment of F tificate of		Mental Hy	giene	006	34726
	п	1. Decedent's Name (First, Middle, Las	st)					2. Date of Do			3. Time of Death
Physici /Medio		Gloria Jewel Wa	rner					October	0 0		7:42 AM
Examir		4a. Facility Name (If not institution, give	/1 ~	1		4b. City, Town, o	r Location of De	ath	4c.	County of Death	
		LORIEN (a)	KIUERSI.	DE		DEL	AMA			HARPV.	(1)
Funeral		Social Security Number     6. S     1	ex 7. Age ☐ M 2 🔯 F	(In yrs. last	birthday) Yrs.	If Under 1 Year Months Days	If Under 24 H Hours Mi	n. (Month, D.		9. Birth Cou	place (State or Foreign ntry)
Director		216-16-6543 Usual Residence of Decedent		82	115.			May 3	192	24 Mary	yland
land		10a. State 10b. County		10c. City, To	own or Lo	cation			-		10d. Inside City Limits
Mary - sh	ō	Mamiland Hareford		Aberd	3000						1 ☐ Yes 2 No
r 28a	Director	Maryland Harford 10e. Street and Number		Aberc	ieen_	10f. Zip Code			10g. Cit	izen of What Cou	intry?
3a o		666 Andrews Roa	ď			2100	1		USA		
deatl	Funeral	11. Marital Status	12. Was Decedent Ev Armed Forces?	er in U.S.	13. \	Vas Decedent of H		(Specify Yes or N		14. Race - Ameri	
ING 21215-0036  be filed within 72 hours after death with the Maryland hat Hyglene.  Ital Hyglene.  d other than "neturel", or Items 23a or 28a-1 show event, the Medical Examinar relastic froitfied at	by Fu	1 ☐ Never Married 2 ☐ Married  3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2 No If Yes, Give			res, specify Cuba	Specify:	erto Hican, etc.)		Black, White, Specify:	
5-0036 72 hours at neturel; or	pa pa	15. Decedent's Ed	Year or Dates:	1.0	6a Decec	lent's Usual Occup	vation		16h K		nite
215-	Completed	(Specify only highest gra	de completed)		(Give	kind of work done	during most of w	vorking	10D. K	ind of Business/Ir	idustry
212 212 3d with giene gr than	E	Elementary/Secondary (0-12)	College (1-4or 5+		Iomem	akor	,		Oram	. Home	
	Be C	17. Father's Name (First, Middle, Last)			MICH		18. Mother's N	ame (First, Middle			
Irylan should be nd Mental marked o	ToB	Garrison (nmn)	Boyle Jr.	•			Eloise	e (nmn)	Hun	iter	
Maryland d 2 should be file th and Mental Hy 7 is marked oth treumetic event	<b>[</b>	19a. Informant's Name/Relationship (			19b. Mailin	g Address (Street	and Number or	Rural Route Numb	er, City o	r Town, State, Zij	p Code)
and 2 and 2 patth (		Dawn E. Tallio /	Daughter		666	Andrews 1	Road, Ak	erdeen,	Mary	land 210	001
altimore, mit. Pages 1 ar partment of Hea portent: If item y injury or othe		20a. Method of Disposition 1	Removal from State	20b. Place ceme	of Dispo	sition (Name of natory or other plac	ce)	Date	20c. Lo	cation - City or T	own, State
Pag Pag ment ent: I		`4 □Donation 5 □ Other (Specify		Coke	sbur	y U.M. Ce	emeterv	11-3-06	Abi	ngdon. N	Maryland
Baltimore, Marylar permit. Pages 1 and 2 should be Department of Health and Menta Importent: If tiem 27 is marked eny injury or other treumetic engines.		21. Signature of Funeral Service Licen	See			Name and Addre					
M 20539	ff f	Algky al	puers		1	317 Cokes	sbury Ro	oad, Abir	ngdon	, Maryla	and 21009
		23a. Part1. Enter the disease, or com- shock, or heart failure. List only	olications that caused the	he death. E	Do not ente				arrest,		Approximate Interval Between
Physician		Immediate Cause (Final disease or condition	a. Meta	stati	ie (	olon (	ancin	oma			Onset and Death
/Medical Examiner		resulting in death)	Due to (or as a	consequen	ce of):						
	7	Sequentially list conditions,	b. — Due to (or as a	consequen	ce of):						
nsit ted	nln	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (01 as a	consequent	CB 01).						
axecu and and	Examiner	that initiated events resulting in death) Last	c Due to (or as a	consequenc	ce of):						
68760, 77 ficate be executed physician and is the burial-transit		(	d								
68 ifficat g phy as the	edical		u.								
Geath certifi	lan/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of 1□Live birth 2			Catania				23d. Date of deliv	ery
• 0 0 0	O	in the past 12 months? 1 \(\sumset \text{Yes}  2 \sumset \text{No} \)	4☐Pregnant at til			Ectopic pregnancy Other (specify)				Month	Day Year
Records, P.O. The law requires that the de tte has been signed by the a bage 2 should be detached t	Physi	9 🗆 Unknown					-	1		11.5	
S, les th igned	by [	Part II. Other significant conditions of	ontributing to death but	not resultin	g in the ur	iderlying cause giv	en in Part I.				he cause of death?
COrd	ted							10	Yes 2	ZNo 3 ☐ Prot	bably 4 Unknown
VItal Records, iicien: The law requires t centificate has been signe rector, page 2 should be o	Completed							24a. Was		prior to co	opsy findings available impletion of cause of
	Cor							perfo 1 ☐ Yes	ZZVo	death?	
Vital Fideicien: The certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:			Oth		eath (Check only	опе)		
	: To	1 Yes 2/2 No 27. Manger of Death	1 Inpatient		Outpatien	3 DOA Oth	Nursing	Home 5 Resi			ý)
Division of Vita for Attending Physicien: after death.  Director: After this certific tin by the funeral director,	tlon	1 Dending 5 ☐ Pending	(Month, Day	Year)	Injury	28c, Injun Work	k? Yes 2 □ No	28d. Describe	now injur	у оссиггөа	
DIVISIO	fica	3 Suicide 6 Could not be		v - At home.	. farm. stre			28f. Location /	Street an	d Number or Rura	al Route Number
Div	Certification:	4  Homicide determined	building, etc.		,	,		City or To	wn, State	)	
DIVI: To the Hospitel or Att within 24 hours after of To the Funerel Direct completely filled in by	edical (	29a. Certifier Certifying Ph	ysicien: To the best of niner: On the basis of e and manner state	xamination	dge, death and/or inv	occurred at the tin estigation, in my o	ne, date and pla pinion, death oc	ce, and due to the curred at the time,	cause(s) date and	and manner as s place, and due to	tated. the cause(s)
To th withir To th comp	Me	29b. Signature and title of certifier		-		29c. Licenso	e pumber	18	29d. Dat	e signed (Month,	Day, Year)
13		30. Name and address of person, who	completed cause of dea	ith (Item 23	a) (Type. I	Print)	1000			11/	
		M. Jokhadar	281 E.	Main	8%	Risin	1 Sur	1, MC	> 2	21911	
Sta	_	31. Date filed (Month, Day, Year)	32. Registrar	s Signature	1	/	/				
Registr		NOV 0 1 200	6	K	dos	K.	<del></del>				

		•	For State Registrar	State of Mar		artment ertificate			nd Me		iene g. N.2 0	06	34727
	Physicia	an	1. Decedent's Name (First, Middle, Last) Virginia Ha	rie Wadde	11					2. Date of Deat Month OCt 2		Yeer	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give s 20 Leppo Rd	treet and number)		4b. City, T		ocation of	Death		4c. Coun	ty of Death	1
8	Funeral		5. Social Security Number 6. Sex	7. Age	'In yrs. last birthday	If Under 1		If Under 2	4 Hrs.	8. Date of Birth (Month, Day, Doc	§		place (State or Foreign untry)
Alay .	Director		213-16-006 Usual Residence of Decedent	M 2DF 8	∠ Yrs.					Dec. 2	5,1923	1	aryland
	anylano ehow	2	10a. State 10b. County Md. Carroll		Oc. City, Town or L Hampste								10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	h the M or 28a-f	Director	10e. Street and Number		manipo co	10f. Zip (				1	0g. Citizen o	f What Cou	untry?
	eath wi	Funeral C		rview Ave	er in U.S. 13.		2107		in? (Spec	cify Yes or No-	U.S		ican Indian,
936	urs after d al', or item	by	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces?  1 Yes 2 No If Yes, Give Year or Dates:	0.0.	If Yes, speci	35	Mexican, Specify:	Puerto F	cify Yes or No- lican, etc.)	В	ack, White	, etc.
Baltimore, Maryland 21215-0036	should be filed within 72 hours after death with the Maryland nd Mental Hygiene. marked other then "naturel", or items 23a or 28a-f ehow marked other then "naturel", or items 23a or 28a-f ehow maric event, the Medical Exeminal me modified at	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Segondary (0-12)	cation completed) College (1-4or 5+)	(Giv	edent's Usual e kind of work DO NOT use Sewife	k done du e retired)	ion ring most	o <i>f worki</i> n	g	16b. Kind of		ndustry
1d 21	filed wi Hygien other th	Be Cor	17. Father's Name (First, Middle, Last)		1100	DOMITE		8. Mother	's Name	(First, Middle, I	Homeni Maiden Suma		
ylar	nould be d Menta narkad natic ev	TO B	Elmer Ruby  19a. Informant's Name/Relationship (Type	- Driet	10h Mai	ing Address	(Street or		7.71	Haines Route Number	City or Tou	- State 7	in Cadal
Mai	and 2 st elth and 127 is n		Forris Waddell			•	'			ter, M			(p Code)
more	permit. Pages 1 and 2 should be Department of Heelih and Menia Important: If item 27 is marked eny injury or other traumatic e one.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	20b. Place of Disp cometery, cre Evergree	ematory or oth	her niare	dens			20c. Location 6 Finl	,	
Balti	permit. Departn Imports eny inju		21. Signature of Funer I Service License	Part		2. Name and Eckhar 3296 C	d Address dt Fi harn	of Facility uners	l Ch	anel P	er. Mo	1. 21	102
· 表	Physician /Medical Examiner	ner	23a. Part. Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury	of dying,	such as o	ardiac or	respiratory arm	est,		Approximate Interval Between Onset and Death  6 weeks			
8760,	ficate be executed physicien and is the burial-transit	dicai Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a	consequence of):								
P.O. Box 68	The law requires that the death certificate be executed the has been signed by the attending physicien and some second be detached for use as the burial-transit.	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 D No 9 □ Unknown	3c. If yes, outcome of 1	Fetal death 3	□Ectopic pre						Date of deliving	very Day Year
	w requires that s been signed b should be deta	Š	Part II. Other significant conditions con	tributing to death but	not resulting in the	underlying ca	ause giver	in Part I.		23e. Did tol	_	ontribute to	the cause of death?
Division of Vital Records,	The law reate has bee page 2 sho	Completed	Hypertensia	~						24a. Was a autops perfore		b. Were aut prior to death? 1 \( \sum \text{Yes}	topsy findings available ompletion of cause of
Vita	rsician: s certific director.	o Be	25. Was case referred to medical examiner?  1 Yes 2 No	ospital: 1 🔲 Inpatient	2 ER/Outpatie	ent 3 DO	Other	-		(Check only on	_	ther (Spec	u(v)
n of	Attending Physician: or death. ector: After this certifica by the funeral director. I	lon: T	27. Manner of Death 1 Alatural 5 Pending	28a. Date of Injury (Month, Day	28b. Time	of 28	Bc. Injury a Work?	at )	2	8d. Describe ho			
Division	or Attendate death Director: in by the	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc.	y - At home, farm, s (Specify)	M treet, factory,		es 2 🗆 N		8f. Location (Si City or Town		nber or Ru	ral Route Number,
_	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Medical C	29a. Certifier (Check only one) 1 ertifying Phys	ician: To the best of ter: On the basis of e and manner state	xamination and/or i	ith occurred a nvestigation,	at the time in my opi	e, date and nion, deat	place, a	nd due to the co	ause(s) and o	manner as e, and due	stated. to the cause(s)
	To th To th compl	Me	29b. Signature and title of certifier	01	. –		License		2		9d. Date sign	1-	/
•	10		30. Name and address of person who co	mpleted cause of dea	ath (Item 23a) (Type	o, Print)	170	20	2		10/	340	06
	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \		4231 W	See Begistrar	s Signature	npste	ned.	MI	) 6	1029	DR	Reb	oeces Goedexe
	Sta Registi		NOV 0 1 2006	Della	A Age	Ne .				_			

			For Stata Registrar	State of Ma	ryland / Depa <i>Ce</i>	artment of rtificate o				giene leg. N2 0 (	06	34728
3	Physici	an	Decedent's Name (First, Middle, Last		471				2. Date of Dea Month	Day	Year	3. Time of Death
	/Medic	al		a Adams Sh	arpe Allei	4b. City, Towr	and another		Octobe:	r 14, 2		2:45 A. M
* 100	Examin	er	4a. Facility Name (If not institution, give Heartland Health	Care Cent	er		ttsvil					orges
	Funeral		of Hyattsville  5. Social Security Number 6. Se	x 7. Age	(In yrs. last birthday)	If Under 1 Ye	ar If Under		B. Date of Birth		9. Birtho	lace (State or Foreign
	Director		579-22-2055	□M 2 <b>X</b> F	95 Yrs.	Months Day	ys Hours	Min.	B. Date of Birth (Month, Day May 12	1911	Nort	h Carolina
	and *		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or Lo	ocation					1	Od. Inside City Limits
	Maryli f eho	ō	District of Colum	bia	Washir							1XYes 2 No
	1 the	Director	10e. Street and Number			10f. Zip Code	8			10g. Citizen of V	Vhat Coun	try?
	th with		1216 Emerson Str	eet, N. W.		20	011			United	Stat	es
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 ie marked other than "natural", or Itema 23a or 28a-f ehow any injury or other traumatic event, Ita Medical Examinar must be notified at once.	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 □ Widowed 4 🏠 Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 N If Yes, Give Year or Dates:	0	Was Decedent of If Yes, specify C 1 ☐ Yes 2X	uban, Mexicar	n, Puerto Ri	ify Yes or No- ican, etc.)		e - Americ k, White, B1	
21215-0036	2 hou	ted	15. Decedent's Edu	cation	16a. Dece	dent's Usual Oc	cupation			16b. Kind of Bu	ısıness/Ind	Justry
218	thin 7	Completed	(Specify only highest grad	College (1-4or 5-	+)	kind of work do DO NOT use ret			9		2.50	
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Maryland	uld be fi fental H rked ot tic ever	To Be	17. Father's Name (First, Middle, Last)  William Adam	ns						e Anne l	-,	t
lary	2 should and A le ma		19a. Informant's Name/Relationship (T	ype, Print) (Daug	hter) <sup>19b. Maili</sup>	ng Address (Stre	et and Number	er or Rural	Route Numbe	r, City or Town,	State, Zip	Code)
	and sealth m 27		Doris Jean Sharpe	B1ake				t,N.W	.;Wash	ington,		
Baltimore,	iges 1 nt of H if ite or ot		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ I		1	matory or other ;	olace)		8,2006	20c. Location -		
Ħ	if. Pa intmer intenti njury		4 □ Donation 5 □ Other (Specify, 21. signature of Funeral Service Local		National	Name and Ad	dress of Facili	ity				aryland
Ba	Depa Impo any i		Dandalph	8 An	$I \longrightarrow I$	R. N. Ho	rton C	ompan	y Mort	icians, ashingto	Inc.	C. 20011
1			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	lications that caused ine cause on each lin	the death. Do not en	ter the mode of o	dying, such as	cardiac or	respiratory ari	rest,		Approximate Interval Between Onset and Death
18	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. CAR	-Bropul	Morep	RYI	4RRE	EST			
	Examiner		1	Due to (or as a	consequence of):	Al I	of far	OCT	in			
- 20		er	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a	consequence of):	10	A Die	*	10.1			
	cuted id ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	. HYPE	RICH!	>1009						
oʻ	e exection ar	Ex	resulting in death) Last	Due to (or as a	consequence of):							
8760,	icate be executed physicien and s the burial-transit	dicai		d								
9	ding p	/Me	IF FEMALE:	23c. If yes, outcome of	of oregnancy					224 Day		
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o.	that the de ned by the a detached	hysi	1 ☐ Yes 2 🛣 No 9 ☐ Unknown	9□ Unknown								
S,	The law requires thet the site has been signed by the bage 2 should be detache	by P	Part II. Other significant conditions co	ntributing to death bu	t not resulting in the L	inderlying cause	given in Part I	l.	23e. Did to	bacco use cont	ribute to th	e cause of death?
ord	w require been signal					_			1 🗆 Y	es 2 <b>X</b> No	3 Prob	abiy 4 □Unknown
Vital Records,	elawr hasbe je 2 sh	Completed							24a. Was a autop	sv c	prior to cor	psy findings available apletion of cause of
a H									1 Yes		death?	2 No
Z:	Physician: This certifice al director, p	o Be	25. Was case relerred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:	4 2Π EΒ/0		0.4		Check only or			
ŏ		-	27. Manner of Death	1 ☐ Inpatier	y 28b. Time o	IL 3 DUA	njury at Work?			ence 6 Oth-		<u>'</u>
ion	Attending r death.	atio	1 X Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day	Year) Injury		Work? □Yes 2□	]No				
Division	l or Attendation of after death Director:	Certification:	3 Suicide 6 Could not be determined	28e. Place of Inju building, etc	ry - At home, larm, st . (Specify)	reet, lactory, offi	се	28	8f. Location (S City or Tow	itreet and Numb n, State)	er or Rura	l Route Number,
_	To the Hospital or Attenwithin 24 hours after deall To the Funeral Director: completely filled in by the	edicai Ce	29a. Certifier 1 Certifying Phy (Check only 2 Medical Exem	rsician: To the best of iner: On the basis of	f my knowledge, deat	h occurred at the	e time, date an	nd place, ar	nd due to the o	cause(s) and ma	nner as st	ated.
	To the H within 24 To the F complete	Medi	one)  29b. Signature and title of certifier	and manner sta	ted.		ense number			29d. Date signed		
1	F S S		255. Giginatar State of the officer	K MI	)	1) (	1-65	9				, 2006
n	(2)		30. Name and address of person who d	ompleted cause of de	eath (Item 23a) (Type	Print)	(04)	-/		octobe!	- 10	, 2000
1	0		Victor C. Onyeji				kway;	Green	belt, l	Maryland	1 207	74
	Sta Registi		31. Date filed (Month, Day, Year)  OCT 1 8 2006	32. Registra	r's Signature	Bi						

			1 - For State Registrar	State of	Marylar				eaith a Death	and M	lental Hyg	jiene (	006	34729	)
	Physic	ian	1. Decedent's Name (First, Middle	e, Last)							2. Date of Dea Month	th Day	Year	3. Time of Death	_
	/Medi	cal	Ellen Brit 4a. Facility Name (If not institution		har)		4. 67.	T	1 2	15 11	October	15	2006	5:57 A	Λ
	Examir	ner		r Mill Rd.	967)		4b. City,		Location of		rh+o		unty of Death	Coomerle	
1/2	Funeral		Social Security Number	6. Sex 7	. Age (In yrs.	last birthday)		r 1 Year	ito1	24 Hrs.	8. Date of Birth (Month, Day	1	9. Birth	George's	רון
100	Director		244-48-5789	1 ☐ M 2 💢 F	77	Yrs.	Months	Days	Hours	Min.			29 Nort	h Carolin	а
	land ow		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	ty, Town or Lo	cation							10d. Inside City Limits	s
	a-feh	tor	Maryland Princ	e George's				Ca	pitol	Ноч	ichto			1 XYes 2 □ No	)
	72 hours after death with the Maryland "natural", or Iteme 23a or 28a-f show collest Exemplat must be notified at	Director	10e. Street and Number				10f. Zip		PICOT	. 116.1		0g. Citizen	of What Cou	ntry?	_
	e 23a		7602 Walker						2074				ited S		
10	fter de	Funeral	11. Marital Status 1 Never Married 2 Marri	12. Was Deced Armed Force 1  Yes 2	es?	.S.   13. \	Was Dece f Yes, spe	dent of Hi cify Cubar	spanic Orig n, Mexican,	jin? (Spe , Puerto i	cify Yes or No- Rican, etc.)		Race - Americ Black, White,	etc.	
036	ours a	by	3	If Yes, Give Year or Dat			1 🗌 Yes	2 <b>X</b> No	Specify:			Spe	ecity:	ican rican	
21215-0036	72 ho	Completed	15. Decedent (Specify onfy highes	's Education it grade completed)		16a. Deced	kind of wo	rk done d	uring most	of workii	ng	16b. Kind o	of Business/In		_
121	withir ene. then he M	dmo	Elementary/Secondary (0-12)	College (1-4	or 5+)	life. I	DO NOT u	se retired)							
d 2	Hygi Hygi ther	Be Co	17. Father's Name (First, Middle, I			Med	ıcaı	Reco	rds P		nnel (First, Middle, I		overnm	ent	_
ılan	Mental Mental arked c	To B	Bolden F. C.	larke							Beatric	e G.	Edward.	s	
Maryland	shand and sm.		19a. Informant's Name/Relationsh				g Address	(Street a	nd Number		Route Number				
	ss 1 and 2 should of Health and Men Item 27 Is marke rother traumatic		Kimberly Marsha	11/Grandda		760 Place of Dispo	)2 Wa	1ker	Mi11	Rd.	, Capit	ol He	ights,	MD 20743	
Baltimore,			1 XBurial 2 ☐ Cremation		ate C	emetery, cren yland	natory`or o	other place	·				on - City or To		
altir	그 문문을	. 8	4 ☐ Donation 5 ☐ Other (Sp. 21. Signature of Fuheral Service L		A.				s of Facility		Stewart		ltenhar ral Hor		
ñ	Depa Impo any i	10	John	· Slewa	J 1			4001	Benn		Rd., NE				
	Physician /Medical Examiner  bhysician and physician and physician the portal fausti	Examiner	23a. Part1. Erfor the disease, or shock, of heart failure. List of the shock of heart failure. List of the shock of heart failure. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Met Due to (or b. Due to (or c.	n ijne.	c Spin uence of):					ospiratory unit			Approximate Interval Between Onset and Death	
P.O. Box 68760,	death certif e attending id for use as	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown	4□Pregnan 9□ Unknow	n 2 Fetal t at time of de	déath 3 = sath 5 =	Ectopic pr Other (sp	ecify)					Date of delive Month	ry Day Year	
	res tha	by F	Part II. Other significant condition	ns contributing to deat	h but not resu	ulting in the un	derlying c	ause giver	n in Part I.			**		e cause of death?	
Sor	w require been sig	eted									-	s 2 🐴 No	3 Prob	ably 4 □Unknown	
Division of Vital Records,	The farate has page 2	e Completed	25. Was case referred to medical								24a. Was ar autopsy perform 1 Yes 2	ed?	prior to con death?	osy findings available npletion of cause of 2 No	
Ž	Physician: r this certific ral director,	To B	examiner?	Hospital:	atient 2	ER/Outpatient	3 □ DO	Other			Check only one		Other (See 4	1	
0 4	ng Ph fter th nerat	L:uc	27. Manner of Death  14 Natural 5 Pending	28a. Date of I		28b. Time of Injury		8c. Injury			8d. Describe ho			/	_
sio	Attending or death.	catl	2 Accident investigation inves	ation			М		as 2 □ No	0					
Σ	s after or At	Certification:	4 Homicide determin	ned 28e. Place of	Injury - At ho etc. (Specify	me, farm, stre	et, factory	, office		21	8f. Location (Str City or Town,	eet and Nui State)	mber or Rural	Route Number,	
	he Hospital n 24 hours a he Funeral pletely filled	edical	29a. Certifier 1 Certifying (Check only one)	Physician: To the be xaminer: On the basis and manner	s of examinat	wledge, death ion and/or inv	occurred a estigation,	at the time in my opi	, date and nion, death	place, ar occurred	nd due to the ca d at the time, da	use(s) and te and place	manner as sta e, and due to	ated. the cause(s)	
	To the within 2 To the complet	Σ	29b. Signature and title of certifier				29c	License				_	ned (Month, E		
	(2)		Meddy,				MI	D	0058	579	Reddy,	0/1	8/04	0	
R.	(3)	- 1	30. Name and address of person w					Sub	ashri +z^^	LS.	Reddy,	M.D.	,		
	Sta	100	31. Date filed (Month, Day, Year)			F7. L	nus	11869	(OVI	1-10	2111	7			
	Registr	ar	OCT 1 9 200	16 Block	1	host	5								

**Physician** Month Maggie Bragg 10 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner coasted Hospice Salisburg ake at If Under 1 Year If Under 24 Hrs.
Months Days Hours Min 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 6. Sex **Funeral** 1 ☐ M 2 🔀 F Yrs. 126-36-0215 Director 82 May 10, 1924 Usual Residence of Decedent deeth with the Maryland 10a. State 10b. County 10c. City, Town or Location r then "neturel", or iteme 23s or 28s-f show the Medical Examiner must be notified at Director MD Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 939 Gateway St., Apt. 308 21801 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 XNo Specify: ģ 3X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Pomestic Worker Elementary/Secondary (0-12) College (1-4or 5+) Various Families 5th other permit. Peges 1 and 2 should be file Depertment of Health and Mental Hy Important: If item 27 is marked other ery injury or other treumatic event, once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Coston Annie Holland 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Schereyll Johnson/daughter 185 St. Mark's Place, Apt. 19E, Staten Island, NY 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Surial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Green Acres Mem Park | 10/13/2006 Salisbury, MD 21. Signature of Euneral Service Ligania 22. Name and Address of Facility Lewis N. Watson Funeral Home 1618 West Rd., Salisbury, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) eritoneal **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner burial-transit Due to (or as a consequence of): Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery

Amend items Registrar 16a, 16b per FH/wichd/10-20-06/Patiticate of Death

1. Decedent's Name (First, Middle, Last)

The law requires that the death certificate be executed ettending physician for use as the buria Division of Vital Records, P.O. Box 68760, signed by the certificate To the Hospital or Attending Physician: this eral Director: Atter thi filled in by the funeral

in the past 12 months?
1 Yes 2 No
9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

4 Pregnant at time of death

3 DEctopic pregnancy 5 Other (specify)

23e. Did tobacco use contribute to the cause of death?

Day

Year

34730

3. Time of Death

7:05 PM

Birthplace (State or Foreign Country)

10d. Inside City Limits

Approximate Interval Between

Onset and Death

1XYes 2 No

Reg. No.

2000

Wicomico

MD

2. Date of Death

9 Unknown

3 Probably 4 Unknown 1 TYes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Yes

Month

25. Was case referred to medical examiner? 26. Place of Death Check only Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 In atient 2 ER/Outpatient 3 DOA

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney

28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No

6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Salish,

1 Yes

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) E. Calell,

postal HOS

31. Date filed (Month, Day, Year) 182006 32. Registrar's Signature

State Registrar

within 24 hours after To the Funeral Dire

Be

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Certification:

Medical

1 Yes No

27. Manner of Death

Natural

3 Suicide

29a. Certifier

2 Accident

4 Thomicide

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene Nathan Gerard Brindle

10-2	:7 <b>-</b> 0	1. For State and #10e.19b. PerFHPGCcr Construction   1. Decedent's Name (First, Middle, Last)	ertificate of Death	Reg No 20	06 3473
Physicia Medical Exami	2100	2. Date of Death  Month Day Year	3. Time of Death 0636 hrs		
*iculcai Exami	rici	Nathan Gerard Brindle  4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	October 19, 2006	
		Baltimore Washington Medical Center	Glen Burnie	Anne Aruno	del
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs.	last birthday) If Under 1 Year If Under 24Hrs  Months Days Hours Min.	_ ` ` 1	Birthplace (State or Foreign Country)
Director		216-73-5175 1XM 2 F 1	Yrs.	Aug. 17,2005	Maryland
any		Usual Residence of Decedent  10a. State	y, Town or Location		10d. Inside City Limits
ž	٦	MD Anne Arundel	Odenton		1 X Yes 2 No
e Maryland or 28a-f show	Director	10e. Street and Number This	10f Zip Code	10g. Citizen of What C	Country?
72 hours after death with the Maryland n "natural", or items 23a or 28a-f sho af Examiner must he notified at once.		2621 Gray <del>Ivis</del> Court	21113	USA	1
ath wit tems 2	Funeral	11. Marital Status 1 Never Married 2 Married Armed Forces?	U.S. 13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto		nerican Indian, Black, c.
ter de: ", or i		3 Widowed 4 Divorced If Yes, Give Year	1 Yes 2 X No specify	Specify	White
5-0036 led within 72 hours afte Hygiene other than "natural", the Medical Examiner	d by	15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's Usual Occupation (Give kind of v		ss/Industry
n 72 h	olete	Elementary/Secondary (0-12) College (1-4 or 5+)	adming most of working line. DO NOT use retil	reu)	
MD 21215-0036 ad 2 should be filed within 72 th and Mental Hygene n 27 is marked other than ' numatic event, the Medical	Completed	17. Father's Name (First, Middle, Last)	18 Mother's Name	(First, Middie, Maiden Surname)	
21215. uld be filed Mental Hy marked of	Be C	Patrick Ryan Brindle		arie Wodarski	
221 hould I nd Mer is mar	P.	19a Informant's Name/Relationship (Type, Print )	19b. Mailing Address Street and Number or F		
		Patrick R. Brindle /father  20a. Method of Disposition 20b	2621 Gray <del>Ivis</del> Court Place of Disposition (Name of cemetery,	Odenton, MD 21  Date   20c Location - City	113
Ore		1 Burial 2 X Cremation 3 Removal from State	crematory or other place)		
or fame property	-	4 Donation 5 Other Specify:  21. Signature of Fugeral Service Licensee	etropolitan Crematory 10,	/26/2006 Alexano eall Funeral Home	
Balt permit Depart Import		Chrim Poull	6512 NW Crain Hwy.		715
Physician		23a. Part I. Enter the disease, or complications that caused the deat failure. List only one cause on each line.	h. Do not enter the mode of dying, such as cardiac o	r respiratory arrest, shock, or heart	Approximate Interval Between Onset and
/Medical Examiner		The state of the s	ned death in childhood		Death
1		b	of):		
	ner	Sequentially list conditions, if any, leading to immediate out E for U Jarlyng Course.	of):	***	
1	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence	of):		+
760, icate be executed physician and the buriat - transit	alE	d			-
760, ficate be ex g physician the burial	Medical		28a-f, perME, g862, 12/27/06		
6876 certificat oding phr		IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pre	gnancy  2 Fetal death 3 Ectopic pregna	23d Date of delivency  Month	very Day Year
Box 68's death certiff the attending	sician	4 Pregnant at time of c	death 5 Other (Specify)	- "	
Records, P.O. Box 68 The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	Phy	Part II. Other significant conditions contributing to death but not	resulting in the underlying cause given in Part I.	23e Did tobacco use contribute	to the cause of death?
, P.( res tha signed be det	d by			1 Yes 2 No 3 P	robably 4 V Unknown
ords,  v requir s been s should	Completed by				autopsy findings available to completion of cause of
Recc The lav icate ha	ome		<del>-</del>	performed? death	
tal Re	BeC	25. Was case referred to medical examiner? Hospital: 1 Innertiant 2.2	26.Place of Death (Check of De	only one)	
of Vital Records, ng Physician: The law requir Niter this certificate has been s noral director, page 2 should t	ပ္	1 Yes 2 No lossification 1 Inpatient 2 2  27. Manner of Death 28a. Date of Injury	P ER/Outpatient 3 DOA Other Nursin  28b Time of Injury 28c Injury at Work?	g Home 5 Residence 6 Ot  28d Describe how injury occurred	her:
ion of V tending Ph eath for: After ti	tion	1 Natural 5 Pending (Month, Day, Year)	1 Yes 2 V No		
Division ral or Attendii rs after death al Director: /	ifica	2 Accident Investigation 3 Suicide 6 X Could not be	home, farm, street, factory, office building, etc.	28f. Location (Street and Number or	
DIVIS Hospital or At 24 hours after d funeral Direct tely filled in by	Certification:	4 Homicide determined (Specify) house		or Town, State) 2161 Ibi Odenton, MD	s Court
= 4 g = 1	_ [	one) 2 Medical Examiner: On the basis of examination	dge, death occurred at the time, date and place, and and/or investigation, in my opinion, death occurred a		
To the within To the Comple	Medica	29b. Signature and title of certifier	29c. License number	29d. Date signed (I	
		Unetz:	O.C.M.E.	October 20, 20	006
0		30. Name and address of person who completed cause of death (Ite		- L	
n g	tate	Ana Rubio MD. Assistant Medical Examiner  31 Date filed (Month, Day, Year)  32 Degistrar's Signa	111 Penn Street, Baltimore, MD 21201		
Regis		OCT 27 2006 Bessen &	7. Speck		

			For State Registrar				rtificate of	Death		Reg. N		6	34	732
r	Physici	an	Decedent's Name (First, Middle, La						2. Date of D Month		)ay 12 10	rear	3. Time o	
排	/Medic	cal		JGGS			4h O'h Taua	and another of Danth	ОСТОВЕ				3:20	P M
	Examir	er	4a. Facility Name (If not institution, given HOLY CROSS HOST)	,				or Location of Death R SPRING		4	lc. County of MONTG		Y	
Y.	Funeral		5. Social Security Number 6. S	Sex 7. Ag	e (In yrs. la		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of B	irth Pay, Yea	1005		ce (State	or Foreign
2.	Director		255-44-2176 Usual Residence of Decedent	7	0	Yrs.			DECEME	BER_	12 (	GEORG	JIA	
	/land ow at		10a. State 10b. Counfy		10c. City,	Town or Lo	cation					10	d. Inside C	ity Limits
	Mary a-f sh ified	tor	MD MONTGOM	IERY	SII	LVER S	PRING						¥∏Yes	s 2□No
	or 28	Director	10e. Street and Number				10f. Zip Code			10g. C	Citizen of Wh	at Countr	y?	
	ath w	rall	2301 GLEN ALLEN				20906				U.S.A			
21215-0036	72 hours after death with the Maryland 'natural', or items 23a or 28a-f show dical Examiner must be notified at	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 ☑ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2 ☒ I If Yes, Give Year or Dates:			Was Decedent of H f Yes, specify Cub 1 ☐ Yes 2 🏋 No	dispanic Origin? (Sp an, Mexican, Puert Specify:	pecify Yes or N o Rican, etc.)	0-	14. Race- Black, Specify:	White, et		
5-0	72 ho natur lical	eted	15. Decedent's E (Specify only highest gra	ducation ade completed)	- 1	16a. Dece	fent's Usual Occup	oation during most of wor	kina	16b.	Kind of Busi	ness/Indu	ıstry	
2	d within 72 housene. Than "natu	Completed	Elementary/Secondary (0-12)	College (1-4or 5	+)			during most of word d) 27D	g		PRT	VATE		
12	filed w Hygie ther tl		6th 17. Father's Name (First, Middle, Last	1		AUI	DETAILE	18. Mother's Nam	e (First Middle	e Maida				
and	ould be f Mental I arked of	o Be	CHESTER BUGGS	,				l .	E MAE G			,		
Maryland	should ind Men is marke umatic	ို	19a. Informant's Name/Relationship	Type. Print)		19b. Mailir	g Address (Street	and Number or Ru	ral Route Num	ber, City	or Town, Si	tate, Zip (	Code)	
	nd 2		LAVERNE BRASWELL/			#28 L	AUGHTON	STREET UP	PER MAI	RLBO	RO, MA	ARYLA	ND 20	0772
ore,	es 1 a of Hec		20a. Method of Disposition	Damaral from State	20b. Pla	ace of Dispo metery, crer	sition (Name of natory or other pla	ce)	Date	20c.	Location - C	ity or Tow	n, State	
ij	Pages nent of 1 ant: if its ury or o		1 ∰ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other ( <i>Speci</i>		FT.			TERY 10/2		1	ENTWOO			
Baltimore,	permit. Pages Department of Important: if it any injury or c		21. Signature of Funeral Service Lice	nsee A				ess of Facility J					HOME 2078	
	_ ' - et		23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused	the death.								Approximat Interval Bet	
	Physician		Immediate Cause (Final disease or condition			Y FAI							Onset and	Death
	/Medical		resulting in death)  Due to (or as a consequence of):											
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	ed sit	Examiner	if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events											
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687	tificate be executed ig physician and as the burial-transit	Medical		u										
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<u>α</u>	s that ned b	by Pł	Part II. Other significant conditions	contributing to death b	ut not result	ting in the u	nderlying cause giv	en in Part I.	23e. Did	tobacco	use contrib	ute to the	cause of	death?
rds	w requires to been signer should be o								1 🗆	] Yes	2 □ No 3	Proba	bly 4 🏋	Unknown
Records,	has has	Completed	<u></u>				-	-	24a. Was auto peri 1∐ Yes	ODSV	pri	or to com ath?	sy findings pletion of c	available cause of
or Vital	ilcian: Th certificate rector, pag	Be C	25. Was case referred to medical examiner?					26. Place of Dea						
) r	8 5	To	1 Yes 2 No			R/Outpatier		4 LI Nursing H						
N C	ng iftel	ion:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Inju (Month, Dag	Year) 2	28b. Time of Injury	Wor		28d. Describe	how inj	jury occurred	d		
Division	Attending r death. ector: After	ficat	2 Accident investigatio 3 Suicide 6 Could not b	e 28e. Place of inju	ıry - At hom	ne, farm, str	M 1 □ eet, factory, office	Yes 2 □ No	28f. Location	(Street a	and Number	or Rural	Route Nun	nber,
2	tai or / s after ai Dire ed in b	Certification:	4 ☐ Homicide determined	building, et	c. (Specify)				City or To	own, Sta	ite)			
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical	29a. Certifier (Check only one) 1 ☑ Certifying Pl	nysician: To the best miner: On the basis o and manner sta	examination	ledge, deatl on and/or in	n occurred at the ti vestigation, in my	me, date and place opinion, death occu	, and due to the rred at the time	e cause e, date a	(s) and manr and place, an	ner as sta id due to f	ted. the cause(	s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	. 0			29c. Licens			29d. D	ate signed (	Month, D	ay, Year)	
			- ywith	i July	en		D566	91		OCI	TOBER	14,	2006	
A	(2)		30. Name and address of person who GHOUSIA SULTANA				-	SILVER SP	RING MA	RYI A	AND 2	0906		
	Sta Registi	_	31. Date filed (Month, Day, Year)  OCT 1 8 200	2. Registra	ar's Signatu	ire -		DI.	<b>9</b> 1111		<u> </u>	5,00		
	3,00		001 - 0 500	-		1								

			For State Registrar	State of Maryland /	Depart Certif	ment of Hea	alth and M eath		ene 006	34733	
ed.	100	S. F.	1. Decedent's Name (First, Middle, La.	st)				2. Date of Death Month		3. Time of Death	
	Physici /Medic	_	SHIRLEY	М.	BU	TLER	(	OCTOBER	12 2006	10:50 A M	
	Examin		4a. Facility Name (If not institution, giv		1	b. City, Town, or Loc			4c. County of Deal		
1.34		2	3984 WARNER AVEN  5. Social Security Number 6. S			LANDOVER I		8. Date of Birth	PRINCE GE	DRGE S	
	Funeral Director		.,	□ M 2CXF 64			lours Min.	(Month, Day, MARCH 8	Year) Co	ORLEANS	
ું			Usual Residence of Decedent					TIANOII O	1)42   1156		
	show	_	10a. State 10b. County PRINCE C	10c. City, Tov	wn or Locat OVER					10d. Inside City Limits 11 Yes 2 □ No	
	8a-f	Director		EORGE 5 LAND				40			
	with t		10e. Street and Number 3984 WARNER AVEN	HIE # 101		10f. Zip Code		10	g. Citizen of What Co	ountry ?	
	ns 23	Funeral	11. Marital Status	12. Was Decedent Ever in U.S.	13. Wa	20784 s Decedent of Hispa	nic Origin? (Spe	cify Yes or No-	U.S.A.	nican Indian,	
က္	or Her		1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 📉 No	If Y	es, specify Cuban, M	fexican, Puerto F	Rican, etc.)	Black, Whit		
03	72 hours after death with the Maryland "natural", or Items 23a or 28a-f show offcel Exeminat he notified at	db	3 ☐ Widowed 4 ☐ Pivorced	If Yes, Give Year or Dates:	1	Yes 2X No S	pecify:		Specify: P	LACK	
21215-0036		Completed	15. Decedent's Éc (Specify only highest gra		(Give kin	it's Usual Occupation of of work done durin			6b. Kind of Business	Industry	
121	withir ene. than	d L	Elementary/Secondary (0-12)	College (1-4or 5+)		NOT use retired)			DDTVADE		
d 2	Hygi Hygi Theri		17. Father's Name (First, Middle, Last,	)	NU		Mother's Name	(First, Middle, M	PRIVATE aiden Surname)		
Maryland	lid be lental rked c	To Be	CLARENCE BUTLER				OLISKE	R STEVE	NSON		
ary	2 should the and Ment is marked aumatic		19a. Informant's Name/Relationship (		•					Zip Code) 20784	
	s 1 and 2 should f Health and Mer item 27 is marke other traumatic		PERCY GOODWIN/S	UN					ER HILLS,M		
Baltimore,			20a. Method of Disposition 1 □NBurial 2 □ Cremation 3 □	comet	of Dispositi ery, cremat	on (Name of ory or other place)	D	ate 2	0c. Location - City or	Town, State	
ţi.	Pag tment tant:		4 ☐ Donation 5 ☐ Other (Specif	W) RESTI		MEM. PK			NEW ORLEAN		
Bai	permit. Page Department of Important: If sny injury or once.		21. Signature of Funeral Service Licer	hall					INS FUNERA R,MARYLAND		
,			23a. Part1. Enter the disease, or con shock, or heart failure. List only	plications that caused the death. Do one cause on each line.	not enter t	the mode of dying, su	uch as cardiac o	respiratory arres	st,	Approximate Interval Between Onset and Death	
	Physician		Immediate Cause (Final disease or condition resulting in death)  a. ALZHEIMERS DISEASE								
The state of the s	/Medical Examiner		Due to (or as a consequence of):								
100		_	Sequentially list conditions, if any, leading to immediate    FAILURE TO THRIVE								
	nsit	Examiner	cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence	o 01 <i>1</i> .						
ς,	execu n and ial-tra	Exar	that initiated events resulting in death) Last	Due to (or as a consequence	e of):		<u> </u>				
8760	rate be executed thy sician and the burial-transit	dicail	(	d							
9	diffical ng phy as th	Medi	IF FELIAL C				-				
Вох	death certificate be executed e attending physician and of for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal deat	th 3□Ed	ctopic pregnancy			23d. Date of del Month	ivery Day Year	
0.	at the dea by the ai tached fo	/s c	1 Yes 2 No	4☐Pregnant at time of death 9☐Unknown	5□0	ther (specify)			Widnin	Day / Oal	
<u>α</u>	that the		Part II. Other significant conditions of	contributing to death but not resulting	in the unde	erlying cause given in	n Part I.	23e. Did toba	acco use contribute to	the cause of death?	
of Vital Records,	sign d be	d by		•		, , ,				obably 4 Unknown	
COL	w requ	lete						24a. Was an	24b Were at	stoosy findings available	
Re	The law ete hes to page 2 si	Completed						autopsy	ed?   death?	topsy findings available completion of cause of	
ta		es	25. Was case referred to medical			26	Place of Death	(Check only one	No 1 Yes	21 No	
<u> </u>	Physician: this certific ral director,	ToB	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatient 2 ☐ ER/O	Outpatient	Other			nce 6 Other (Spe	cify)	
			27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Injury 28b. (Month, Day Year)	. Time of Injury	28c. Injury at Work?	2	8d. Describe how	v injury occurred		
sio	eat or:	catl	2 Accident investigation 3 Suicide 6 Could not b				2 🗆 No				
Division	- 5 th 6	Certification;	4 Homicide determined	28e. Place of Injury - At home, f building, etc. (Specify)	tarm, street	, factory, office	2	City or Town,	et and Number or Ri State)	ural Route Number,	
	spita ours herai filled		29a. Certifier 1 Certifying Ph	tysician: To the best of my knowledge	ge, death o	ccurred at the time, of	date and place, a	nd due to the cau	use(s) and manner as	stated.	
	1 2 2 at	Medical	(Check only 2 Medical Examone)	miner: On the basis of examination a and manner stated.	and/or inves	tigation, in my opinio	on, death occurre	d at the time, dat	e and place, and due	to the cause(s)	
	To the within 2 To the complet	Me	29b. Signature and little of certifier			29c. License nu	mber	29	d. Date signed (Mont	h, Day, Year)	
			bulgh le	Il.		D2278	3	C	CT. 13,	2006	
1)	(10)		30. Name and address of person who			nt)					
			PETER SCHISSIER  31. Date filed (Month, Day, Year)	M.D. 7500 GREENW			/E # 430	GREENBE	LT, MARYLA	ND 20770	
1	Sta Registi	_	OCT 1 8 200	. Registrar's Signature	Good						

State of Maryland / Department of Health and Mental Hygien 2006 34734 1 - For State Registrar Certificate of Death Reg. No. 1 Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** OCTOBER 15 2006 5:20 A M BALDWIN SONJIA /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 11003 RHODENDA AVENUE UPPER MARLBORO PRINCE GEORGE'S If Under 1 Year If Under 24 Hrs. 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 1971 **Funeral** Davs Hours NEW YORK Months 1 M 2 F 083-58-5859 34 Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Item 27 is marked other than "natural", or Items 23s or 28s-f show other traumatic event, the Madical Examinar must be notified at 1 Yes 2 □ No Director PRINCE GEORGE'S UPPER MARLBORO 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code With 11003 RHODENDA AVENUE 20772 U.S.A. death Funeral 12. Was Decedent Ever in U.S. Amed Forces?
1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 and 2 should be filed within 72 hours after. Health and Mental Hygiene. em 27 is marked other than "natursi", or ite 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: BLACK If Yes, Give The Year or Dates: Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 4 YRS SCIENTIST PRIVATE 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be DAVID HARRIS VICKI BOYD 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  $2\overline{0772}$ 19a. Informant's Name/Relationship (Type, Print) of Health TIMOTHY BALDWIN SR./HUSBAND 11003 RHODENDA AVENUE UPPER MARLBORO, MARYLAND 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of Hi
Important: if Ites
any injury or oth t Durial 2 Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) RESURRECTION CEMETERY 10-21-2006 CLINTON, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death fmmediate Cause (Final **Physician** BREAST CANCER disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially fist conditions, Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, attending physicien Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No ૃં Month Day Year 5 Other (specify) 4☐Pregnant at time of death P.0. the a detached Š Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ pe 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown been sig Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 24 No 24a. Was an certificate has page 2 autopsy med? 2 □ No 1 Yes Hospitel or Attending Physicien: 25. Was case referred to medical examiner? director, Be 26. Place of Death | Check only one) Hospitaf: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 XNatural 5 Pending investigation efter death.

Director: Af
d in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 24 hours e 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. within 2 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) D45880 10-17-2006 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1396 PICCARD DRIVE ROCKVILLE, MARYLAND LEON HWANG M.D. 31. Date filed (Month, Day, Year) State OCT 1 8 2006 Registrar

e)		= State Registrar	State of Maryland	Cer	riment of F tificate of	ieaith and Death	ı Mental Hy	rgiener Reg. No.	2006	3473
Physiciai /Medica Examine	n al -	1. Decedent's Name (First, Middle, Las La. Facility Name (If not institution, give	BUTLER	2	4b. City, Town, o	r Location of De	2. Date of D Month	13	Year O 4 County of Dea	
Funeral Director	2	5. Social Security Number 6. Sec. 215-88-5549  Usual Residence of Decedent	1 Age (In yrs. 1 X M 2□ F 40	nter last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hours M	8. Date of 8 (Month, D	ay, Yəar)		thplace (State or Foreig ountry) RYLAND
deeth with the Maryland	ctor	MD 10b. County PRINCE G	EORGE UPP	PER MAR	LBORO			-	en of What C	10d. Inside City Limit 1 X Yes 2 □ N ountry?
urs after	by Fur	15310 PEERLESS AV  11. Marital Status  1 X Never Married 2 Married 3 Widowed 4 Divorced	LE. Was Decedent Ever in U. Armed Forces?  1 ☐ Yes 2 M No If Yes, Give Year or Dates:	If	20772  Vas Decedent of H Yes, specify Cubic  ☐ Yes 2 ☑ No	lispanic Origin? an, Mexican, Pu Specify:	(Specify Yes or N erto Rican, etc.)	0- 1	U.S.A. 4. Race - Am Black, Whi	
d within 7 plene. r than "n	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12) 12th	ucation de completed) College (1-4or 5+)	(Give F life. D	ent's Usual Occup kind of work done O NOT use retired	during most of (	working Name (First, Middle		PRIVAT	•
8 2 2 6	To Be	JAMES T. BUTLER  19a. Informant's Name/Relationship (7)	ype, Print)	19b. Mailin	g Address (Street	ANNETT	E MARIE	BELT		Zip Code)
it. Page rtment o rtant: if njury or		JAMES T. BUTLER/F  20a. Method of Disposition  1 □ Burial 2 □ Cremation 3 □  4 □ Donation 5 □ Other (Specify  21. Signature of Funeral Service Licen	Removal from State RES	lace of Disposemetery, crem URRECT	ition (Name of atory or other place ION CEME	TERY10-	PPER MARI Date 19-2006 B JENKINS	20c. Loc	cation - City o	Town, State
Physician /Medical		23a. Part1. Enter the disease, or comp shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a CADDì C	Do not ente	r the mode of dyir	ng, such as card	LANDOVER		20785	Approximate Interval Between Onset and Death
cate be executed we have cate be executed why sicien and the burial-transit and the burial-	and the	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence.  Due to (or as a consequence)	SEP (to exneu AID		TO IM	MAHE DE	Fi'ai E)	ertex	
in the death certificate be executed by the ettending physicien and lached for use as the burial-transit	Me /Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregna 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown	death 3	Ectopic pregnancy Other (specify)	,		2	3d. Date of de Month	livery Day Year
igned b	2	Part II. Other significant conditions of	ontributing to death but not resu	ulting in the un	derlying cause giv	en in Part I.			/	o the cause of death?
ete has b	Completed						24a. Wa auto per 1 🗆 Yes			utopsy findings availa completion of cause of s 2 No
his cert	0 0	25. Was case referred to medical examiner?  1  Yes  25 No  27. Manner of Death 1 Natural  5  Pending 2  Accident investigation	28a. Date of Injury (Month, Day Year)	ER/Outpatient 28b. Time of Injury	28c. Injur Wor	er: 4 🗆 Nursin	g Home 5 Res	idence 6		acify)
Hospital of Attending 24 hours effer death. Funeral Director: Attel tely filled in by the fune	al Certification:	3 Suicide 6 Could not be determined		v)		me date and si	City or To	wn, State)		tural Route Number,
5 5 5 6 6 6 6 6 6 6 6 6 6 6 6 6 6 6 6 6	Medical		inier: On the basis of examinal and manner stated.	tion and/or inv	estigation, in my o	pinion, death o	ccurred at the time	, date and	place, and du	e to the cause(s)
i		June	completed cause of death (Item	1 23a) (Type, F	Doc	010	52	10	11410	70

State of Maryland / Department of Health and Mental Hygiene 1- State Registrar Per infor.gc, 10/24/06 Amended #11 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death October 14, 2006 **Physician** Robert J. Bello 2:07 P M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Prince George's Hospital Cheverly Prince George's | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. | 1 1-9-1948 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral №** M 2□ F 214-52-3929 57 Yrs. Kentucky Director Usual Residence of Decedent the Maryland 10a State 10h Counts 10c. City, Town or Location 7 is marked other then "naturel", or items 23e or 28e-1 show treumatic event, the Madical Examinar must be notified at 10d. Inside City Limits MD Prince George's Greenbelt Director XXYes 2□No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7700 Hanover Parkway 20770 Apt T-3United States death Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 Ares 2 No 1969 - Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 and 2 should be filed within 72 hours after of Health and Mental Hygiene. em 27 le marked other then "naturel", or Itel 1 Never Married Married Baltimore, Maryland 21215-0036 Specify: White 1□Yes 2 No þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Auto Mechanic Park & Planning Comm. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Anthony J. Bello Stephaine M. Staelens 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anthony Bello (Father) 5612 Ellerbie Street Lanham, MD 20706 item 27 i 20b. Place of Disposition (Name of cemetery, crematory or other place) t. Pages 1 rtment of P ortent: If it 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 □ Cremation 3 □ Removal from State Fort Lincoln Cemetery 10/18/2006 Brentwood, MD <sup>¹</sup> 4 □ Donation 5 □ Other (Specify) permit.
Dep rtr
Importe
any nju 22. Name and Address of Facility Fort Lincoln Funeral Home 3401 Bladensburg Road Brentwood, MD 20722 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) a Ventricular Fibrillation /Medical Due to (or as a consequence of) Examiner Dialeted Cardiomyopathy 5 ears Sequentially list conditions Due to (or as a consequence of): Examiner cause. Enter Underlying Cause (Disease or injury The law requires that the death certificate be executed burial-transit Aortic Value Insufficiency that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical phys the t IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death Month Day Year 5 Other (specify) P.O. the 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. Be Completed by Pulmonary Hypertension 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? page 2 s 24a. Was an autopsy performed? 2X No 1 ☐ Yes 2 ☐ No 1 Yes Hospitel or Attending Physicien: 25. Was case referred to medical 26. Place of Death Check on one examiner? examiner? X No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To M Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred injury 5 Pending death. 1 ☐ Yes 2 ☐ No investigation М 2 Accident after death Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide filled in 24 hours a 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical npletely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29b. Signature and title of certifie 29c. License number D 00 28 195 29d. Date signed (Month, Day, Year) WD. 10/15/2006 30 Name and address of person who completed cause of death (Item 23a) (Type Print) 20774 Largo, MD 20774 David Gooray, MD 31. Date filed (Month, Day, Year) State Blede & Sparte Registrar OCT 1 7 2006

			For State Registrar	State of Maryl		artment of H			iene ag. No. 006	34737
			Decedent's Name (First, Middle, La.	st)				2. Date of Deat		3. Time of Death
	Physici		Daija Janay	Carter				Month	Day Year 14, 2006	6:50 a <sup>M</sup>
	/Medic Examin		4a. Facility Name (If not institution, give			4b. City, Town, or	Location of Death		4c. County of Dea	
	Exami	ei	Southern Maryla			Clin	ton		Prince	Georges
	Funeral		5. Social Security Number 6. S		yrs. last birthday)	if Under 1 Year	If Under 24 Hrs.	8. Date of Birth (Month, Day,		rthplace (State or Foreign ountry)
н	Director		216-65-8043	□M 2□XF	3 Yrs.	Months Days	Hours Min.	Oct. 29	2002 Was	hington.D.C.
			Usual Residence of Decedent					, occ. 25	2002    1145	iningcon, p.o.
	ylan		10a. State 10b. County		. City, Town or Lo					10d. Inside City Limits
	Ma -	Director	Maryland Prince (	Georges	Foresty	ville				1∑Yes 2□No
	r 28	le	10e. Street and Number			10f. Zip Code		1	0g. Citizen of What C	ountry?
	23a c	a	6013 Rose Bay Dr.			2074	7		United St	ates
	dee F	Funeral	11. Marital Status	12. Was Decedent Ever Armed Forces?	in U.S. 13.1	Was Decedent of H	ispanic Origin? (S	pecify Yes or No-	14. Race - Am Black, Wh	
Maryland 21215-0036	2 should be filed within 72 hours after deeth with the Maryland and Mental Hyglene. Is marked other than "naturel", or Iteme 23a or 28a-1 ehow aurnatic event, the Madical Exporter number profiling at	by Fu	1 ★ Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		1 ☐ Yes 2 ☑ No	Specify:	o Filoan, otc.,	Specify: B	_
ğ	2 hot	ed	15. Decedent's E		16a. Dece	dent's Usual Occupa	ation		16b. Kind of Business	/Industry
5	n n	Completed	(Specify only highest gra		(Give	kind of work done o DO NOT use retired	during most of wor ()	king		•
2	the diameter	E	O	College (1-4or 5+)		N/A			N/A	
ਰੂ	Hyg othe	0	17. Father's Name (First, Middle, Last,	)			18. Mother's Nan	ne (First, Middle, M	<del></del>	
<u>a</u>	ked be	To B	Darrell J. Carte	er			Kriste	n Rutledg	ge	
3	shound N	-	19a. Informant's Name/Relationship (	Type, Print)	19b. Mailir	ng Address (Street	and Number or Ru	ral Route Number	City or Town, State,	Zip Code)
Š	od 2 27 is		Kristen Rutledge	e/ Mother	6013	Rose Bay	Dr. Fore	estville,	Md. 207	47
စ်	f Hear		20a. Method of Disposition	20	b. Place of Dispo	sition (Name of natory or other plac	1 (00	Date	20c. Location - City o	Town, State
6 E	age onto		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif	Inemoval hom State	Resurred			21.2006	Clinton,	Md.
Baltimore,	artm orter injur		21. Signature of Funeral Service Licer	9						
ñ	permit. Pages 1 and 2 should be Department of Health and Menta Important: if item 27 is marked eny injury or other traumatic e ODGs.		+ Potth CIL	tense 100	06	S138 Mar	r S. Pop Iboro Pil	ke/Forest	Homes, P	A·20747
		Н	23a. Patt1. Enter the disease, or com shock, or heart failure. List only							Approximate
			Immediate Cause (Final	one cause on each line.	ure					Interval Between Onset and Death
	Pnysician /Medical		disease or condition resulting in death)	a		994				
	Examiner			Due to (or as a cor	4	3				
		-	Sequentially list conditions, if any leading to immediate cause. Enter Underlying	b. Due to or as a con		)				
	ted nsit	를	Cause (Disease or mury							
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687	icate phys	dlcal		_ 0.						
	certif Iding Ise a	N N	IF FEMALE:	23c. If yes, outcome of pre	egnancy				23d. Date of de	diver
Вох	The law requires that the death certific ste hes been signed by the ettending p page 2 should be detached for use as	Physiclan/Me	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 2 ☐ I 4 ☐ Pregnant at time	Fetal death 3	Ectopic pregnancy Other (specify)			Month Month	Day Year
o.	that the de led by the detached	ysi	1 □ Yes 2 □ No 9 □ Unknown	9□ Unknown	0. 302					
۵.	es that igned by be deta	4	Part II. Other significant conditions of	contributing to death but not	resulting in the u	nderlying cause give	en in Part I.	23e. Did tob	pacco use contribute (	o the cause of death?
ds	sign d be	d by						1 □ Ye	s 2 1 No 3 P	robably 4 Unknown
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ĕ	e lav	ם						24a. Was a autops perform	v prior to	utopsy findings available completion of cause of
æ	Physician: The this certificate here: al director, page									s 2□ No
Ë	iciar certif ecto	Be	25. Was case referred to medical examiner?	Hospital:		Oth	00	th Check only on		
o	Physician: r this certifica ral director, p	10	1 Yes 2 No	1 Unpatient	2 ER/Outpatier 28b. Time of	IL SEMECA	4 🔲 Nursing n		nce 6 Other (Spi	ecify)
		6	1 Natural 5 Pending	28a. Date of Injury (Month, Day Yea	(r) Injury	Worl	Yes 2 □ No	280. Describe no	w injury occurred	
<u>S</u>	Attending r death. sctor: After by the fune	cal	2 Accident investigation 3 Suicide 6 Could not b	e Zoo Blood of Injury	At home form str		163 2 1140	29f Location /Ct	reet and Number or F	hural Courte Musebas
Division of Vital Records,	는 를 들	Certification:	4  Homicide determined	building, etc. (Sp	ecify)	eet, lactory, office		City or Town	, State)	urai noute ivumber,
_	Hospital or 24 hours effe Funeral Dir tely filled in		29a. Certifier 1 Certifying Ph	nysician: To the best of my	knowledne deati	occurred at the time	ne date and place	and due to the or	suse(s) and manner a	nate 2
		Medical	(Check only 2 Medical Exar	miner: On the basis of exar and manner stated.	mination and/or in	vestigation, in my of	pinion, death occu	rred at the time, da	ate and place, and du	e to the cause(s)
	To the within 2 To the pomple	Me	29b. Signature and title of certifier			29c. License	e number	25	9d. Date signed (Mon	th, Day, Year)
	- > -		Mer	- N		Dogo	5526	9	10/11/21	060
. /	1/7		30. Name and address of person who	completed cause of death	(Item 23a) (Type	Print)		,	1-1161	
1	4')		// -	LICORO M.	D 91.5	2 fens	Ave	Voner 1	10/16/ Un/bro	PUD
	Sta	te	31. Date filed (Month, Day, Year)	#2. Registrar's S	ionature -			11	- 2	
	Registi		OCT 1 9 2008	Secre !	K Appe					
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State of Maryland / Department of Health and Mental Hygien ) 34738 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) OCTOBER 6 2006 **Physician** 7:00 A M CHAPPELLE III MITCHELL /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** PRINCE George'S PRINCE GEORGE'S HOSPITAL CHEVERLY If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min. 1☑M 2□F 81 267-26-5321 FLORDÍA 11-19-1924 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10b. County 10c. City. Town or Location 10a. State or then "netural", or Items 23s or 28s-f ehow The Medical Examinar must be notified at Yes 2 No PRINCE GEORGE'S FT. WASHINGTON Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20744 U.S.A. 319 BARON COURT Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: BLACK Specify: þ 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) GOVERNMENT Etementary/Secondary (0-12) al Hygiene. 5+ LETTER CARRIER 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) parmit. Pagas 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked other properties of the traumatic event 2008. MITCHELL P. CHAPPELLE JR. MABEL GARDNER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1206 FACTORY STREET CARLISLE, PA 17013 MITCHELL P. CHAPPELLE IV/SON 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition t □ Burial 2 ☑ Cremation 3 □ Removal from State RIVERDALE CREMATORY | 10/10/2006 | RIVERDALE, MARYLAND 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure). List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Cer /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine The law requires that the death certificate be executed as the burial-transit resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. attending physician Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Month Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☑ No 3 Probably 4 Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? certificate 3 No 1 Yes 1 TYes within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of fnjury (Month, Day 28c. Injury at Work? 27. Mannes of Death 28b. Time of 28d. Describe how injury occurred Injury Year 1 Natural 5 Pending М 1 Yes 2 No 2 Accident 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \( \text{Homicide} \) 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medicai 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License numbe 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier 10-6.0

State Registrar

OCT 1 8 2006

31. Date filed (Month, Day, Year)

32. Registrar's Signature

30. Name and address of person who completed cause of death (ftem 23a) (Type, Print) 12700 (500 MICC) promise of

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			For State Registrar	State of M	aryland / Dep	partment of F ertificate of	lealth and Death		giene 0	6 34739
	Physici	200	1. Decedent's Name (First, Middle, Las	st)				2. Date of De. Month	Day Ye	3. Time of Death
	/Medic		Nelson Y.C.	onavis	25			OCT		co61523 M
	Examin	er	4a. Facility Name (If not institution, given HOWAPD CO.	street and number, GON BILL		4b. City, Town, o	mein	, mo	4c. County of I	
	Funeral Director		5. Social Security Number 417–38–9320 6. S	ex 7. A( ☐ M 2 ☐ F	ge (In yrs. last birthda 74 Yrs.	y) If Under 1 Year Months Days	If Under 24 H Hours Mi		y, Year) g. 932 Z	Birthplace (State or Foreign Country) Alabama
	pg &		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or	Location				10d. Inside City Limits
	Maryla -1 eho	tor	Md. Howard		Columb					1 ☐ Yes 2 ☐ No
	th with the 23a or 28a	ai Director	10e. Street and Number 9210 May Day 0	Ct.		10f. Zip Code	21045		10g. Citizen of Wha	nt Country? JSA
36	72 hours after death with the Maryland Insturet; or items 23s or 28s-f ehow digal Examinat must be notified at	y Funerai	11. Marital Status  1 Never Married 2 Married	12. Was Decedent Armed Forces' 1 Syes 2 U If Yes, Give Year or Dates:	№1953-	3. Was Decedent of H If Yes, specify Cub		(Specify Yes or No erto Rican, etc.)	- 14. Race - Black, \ Specify:	American Indian, White, etc. White
5-0036	"neturel",	ted by	3 ☐ Widowed 4 ☐ Divorced  15. Decedent's Ed	ducation	16a. Dec	cedent's Usual Occur	ation		16b. Kind of Busin	
21215	within liene. r then	Completed	(Specify only highest gra Elementary/Secondary (0-12)	College (1-4or	5+) life	ve kind of work done DO NOT use retire Colonel	d)		M	ilitary
Maryland 2121	ould be filed v Mental Hygle arked othar i	To Be C	17. Father's Name (First, Middle, Last)  Louis S. Conor	-				ame (First, Middle,		
J/J	d 2 should be th and Menta 7 ie marked treumatic ev	F	19a. Informant's Name/Relationship (		19b. Ma	iling Address (Street	-			te, Zip Code)
	ad 2 15 in a		Elizabeth J. Conor	ver/wife	9210	May Day C	t. Colu	mbia,Md.2	21045	
Baltimore,	S to I		20a. Method of Disposition 1 ☐ Burial 222Cremation 3 ☐			position (Name of rematory or other pla		Date	20c, Location · Cit	
草			4 □Donation 5 □Other (Specification 21. Signature of Funeral Septice Liser			ematory Ir				Lie,Md. nily F.H.Inc.
Ba	Depertrice imports eny inju		I Condre P. O	mato						y,Md. 21043
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	Physician /Medical		disease or condition resulting in death)	a. Mali	a onsequence of):  ortensic  a consequence of):	arry	th mid	2 5		
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	ted nsit	Examiner	Sequentiatly list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury	Due to (br as	a consequence of):		( )	1		
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8760,	cate be physici the bu	dical	•	d						
Box 6	eath certific ettending p	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome					23d. Date o	f delivery
.O. B	The law requires that tha death certificate be executed the has been signed by the eltending physicien and bage 2 should be detached for use as the bural-transit	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown			B □Ectopic pregnanc	/ 		Month	Day Year
s, P.	res that igned by be deta	by Ph	Part II. Other significant conditions of	ontributing to death I	but not resulting in the	underlying cause giv	ren in Part I.	23e. Did to		te to the cause of death?
ord	w requir been si should I	eted						-		Probably 4 Unknown
of Vital Records,	The law sete has I page 2 s	Completed							med? prior	re autopsy findings available r to completion of cause of th?  Yes 2 No
ita		Be C	25. Was case referred to medical examiner?				26. Place of D	1 ☐ Yes eath (Check only o		165 2 100
<u>&gt;</u>	Physician: this certific ral director,	10	1 ☐ Yes 2 No		ent 2 ER/Outpat		4 🗆 Nursing	Home 5 ☐ Resid	dence 6 Other (	Specify)
	ding After fune	tion:	27. Manner of Death  1. ■Naturat 5 Pending  2. Accident investigation	28a. Date of Inj (Month, Da	ay Year) 28b. Time Injury	Wo	yat k? Yes 2 □No	28d. Describe	now injury occurred	
Division	l or Attending effer death. Director: Afte in by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not b 4 Homicide determined	e 28e. Place of In	jury - At home, farm, tc. (Specify)			28f. Location (3 City or Tox	Street and Number o	or Rural Route Number,
Ω	pital o		29a, Certifier 1 Cartifying Ph	veician. To the hes	t of my knowledge, de	ath occurred at the ti	ne date and nia	ce, and due to the	cause(s) and mage	or as stated
	To the Hospitel or At within 24 hours effer of To the Funeral Direct completely filled in by	edicai		ninar: On the basis of and manner s	of examination and/or	investigation, in my	ppinion, death oc	curred at the time,	date and place, and	due to the cause(s)
	Mithin To the Company of the Company	X	29b. Signature and title of certifier	1		29c. Licens			29d. Date signed (A	
			hevan	ruch	m D	0 2	2500		05 16	2006
) <u>o</u>	ع		30. Name and address of person who	completed cause of	death (Item 23a) (Typ	e, Print)	Colur	nbia	, mo 2	1044
	Sta Registi		30. Name and address of person who LEVAN Ke C 31. Date filed (Month, Day, Year)  OCT 1 9 2	32. Agist	rar's Signature	back				

		1 - For State Registrar	State	of Mary		artment of <i>rtificate o</i>		d Mental Hy	_	006	34740
Physici /Medic		1. Decedent's Name (First, Middle Daniel Gerare						2. Date of De		, 2006	3. Time of Death 5:45 a M
Examin		4a. Facility Name (If not institution Howard's House  5. Social Security Number	_	Livin	g yrs. last birthday	Tane	or Location of Deytown		C	County of Death	
Funeral Director		217–40–7022 Usual Residence of Decedent	1 <b>2</b> M 2□ F	6		Months Day		Min. Oct 23	y, Year)	Cour	
e Marylan 3a-f show diffisd at	ctor	Maryland Carr		100	c. City, Town or L	ocation	Taneyto	wn		1	0d. Inside City Limits 1 ☐ Yes 2 No
th with th 23a or 20	Funeral Director	10e. Street and Number 4949 Middleburg	Road			10f. Zip Code	21787		10g. Citîz	zen of What Cour	itry?
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Dep firment of Health and Mentalle Hygiene. Dept. Internet of Health and Mentalle Hygiene. Internet if it is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic avent, the Medical Examinat must be notified at once.	þ	11. Marital Status  1 Never Married 2 Mar  3 Widowed 4 Divorced	nied 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	cedent Ever Forces? 5 2 No Sive Dates: I	Viet Nam	1□Yes 2 N	lo Specify:	? (Specify Yes or No uerto Rican, etc.)		4. Race - Americ Black, White, Specify: wh	
iled within 72 h Hygiene. Her than "nati nt, The Medica	Completed	15. Deceder (Specify only higher Elementary/Secondary (0-12) 12 17. Father's Name (First, Middle,	College 4	(1-4or 5+)	(Give	dent's Usual Occ e kind of work dor DO NOT use reti Countant	ne during most of red)		Stat	nd of Business/Ind ce of Maryland	ŕ
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Tand 2 should be a		19a. Informant's Name/Relations Frances G. Nola 20a. Method of Disposition	Form	pouse		kylark '	Prail, F	airfield,	PA 1		
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permit. Dep rin Imports any inju		21. Signature of Funeral Service	Licensee	M0119	<sup>2</sup>	2. Name and Add	ress of Facility   LE Stree	Myers-Durl t, Westmin	oraw ister	Funeral , MD 211	L Home 157
Physician /Medical		23a. Part1 Enter the disease, or shoot or heart failure. List Immediate Cause (Final disease or condition resulting in death)	complications that only one cause on a	caused the each line.	death. Do not en	ter the mode of d	ying, such as care	diac or respiratory a	rest,		Approximate Interval Between Onset and Death
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ath certitic	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		birth 2 🗍 gnant at time	Fetal death 3[	□Ectopic pregnar □ Other (specify)	icy		23	3d. Date of delive Month	ry Day Year
w requires that the de-	d by	Part II. Other significant conditi	ons contributing to	death but no	t resulting in the u	nderlying cause (	given in Part I.		bacco us		e cause of death?
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nding Physician: The th.: Atter this certilicate h e luneral director, page	ation: To Be	25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death  1 Tatural 5 Pendir 2 Accident investi	Hospital: 1 [	Inpatient e of Injury onth, Day Yea	2 ER/Outpatier 28b. Time o	f 28c. In	ther: 4 Nursin	Death (Check only o g Home 5 Tesic 28d. Describe h	ence 6	The State of the S	assisted
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+1 Grats		30. Name of d address of person	who completed car	MD	(Item 23a) (Type.	Print)	Real	Westma	25.7.	er m	D 21157
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			Registrar  1. Decedent's Name (First, Middle)	. Last)		00	tineate of i	Jean	2.	Date of Dea	eg. No.	_ 0 0 0	3. Time of Death
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F	/Medio Examin		4a. Facility Name (If not institution,		er)		4b. City, Town, or	Location o	of Death		4c.	County of Dear	
			Crofton Convales	cent & Reh	ab. Ct	r.	Crofton				An	ne Arun	idel
	Funeral		,	6. Sex 7. 1 □ M 2 🛣 F	Age (In yrs. I	* .	If Under 1 Year Months Days	If Under :	24 Hrs. 8. Min.	Date of Birth (Month, Day 7/20/1	Year)	Co	thplace (State or Foreign puntry)
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	or 28	ire	10e. Street and Number				10f. Zip Code			1	0g. Citi:	zen of What Co	ountry?
	ath w	Funeral Director	400 Honeywood Co				21108					ed Stat	tes
	er de	une	11. Marital Status	12. Was Decede Armed Force	s?	S. 13.	Was Decedent of H f Yes, specify Cuba	ispanic Orig In, Mexican	gin? (Specify , Puerto Ric	y Yes or No- an, etc.)	1	<ol> <li>Race - Ame Black, Whit</li> </ol>	
35	be filed within 72 hours after death with the Maryland ital Hygiene. Id other then "natural", or items 23a or 28a-f ehow event, I're Medical Examiner must be motified at	by F	1 ☐ Never Married 2 ☐ Marrie 3 ☑ Widowed 4 ☐ Divorced	ed 1 ∐ Yes 201 If Yes, Give Year or Date			1 ☐ Yes 2 🛣 No	Specify:				Specify: Whi	ito
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Maryland 21215-0036		Be	17. Father's Name (First, Middle, L	ast)						irst, Middle, I		,	
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Baltimore,	permit. Pag Department Important: f eny injury o		21. Signature of Funeral Service L				. Name and Addres						
ñ	g G E 9		funt or the	<i></i>		2	973 Solom	ons I	sland	Rd.,E	dgev	vater. N	MD 21037
			23a. Part1. Enter the disease, or of shock, or heart failure. List of	complications that cause on each	sed the death								Approximate Interval Between
ĭ	Physician		Immediate Cause (Final disease or condition	_a. Cerefy	0119114	lov a	LLIND						Onset and Death
<i>f</i>	/Medical Examiner		resulting in death)		as a consequ	ience of):							
	Examiner	_	Sequentially list conditions,	b. Duratific	as a cunsequ	week off							
Т	nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	200 (0 (0.	as a consequ	131.00 017.							1
Š	be executed sician end burial-transit	Exa	that initiated events resulting in death) Last	C. Due to (or	as a consequ	ence of):							
9/9	death certificate be executed e attending physician end id for use as the burial-transit	dicai		d									
Õ	ng ph as th	Med	IF FEMALE:								-		
žog	eath certific attending p I for use as i	an/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcor	ne of pregnar 2 ∐ Fetal		Ectopic pregnancy				2	3d. Date of del	ivery Day Year
	at the dea by the a tached fo	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant 9□Unknowr	t at time of de	eath 5□	Other (specify)					Month	Day Teal
٦.	that the		Part II. Other significant condition	s contributing to death	h but not resu	Iting in the u	nderlying cause give	en in Part I	1	23e. Did tot	pacco u	se contribute to	the cause of death?
ďS,	law requires that the es been signed by th 2 should be detache	d by					, , , , , , , , , , , , , , , , , , , ,				es 2[		
ecord	w require been sig should b	lete				_				24a. Was a	n	24h Were au	itopsy findings available
r	The lay	Completed								autops perform	y ned?	prior to death?	completion of cause of
VITa		0	25. Was case referred to medical	-				26. Place	of Death /C	1 ☐ Yes 2	No P	1 🗆 Yes	250No
	Physician: rthis certific ral director,	ToB	examiner? 1 ☐ Yes 2 No	Hospital: 1 ☐ Inpa	atient 2 🗆 E	ER/Outpatien	t 3□ DOA Othe					☐Other (Spec	cify)
			27. Manner of Death 1 Matural 5 ☐ Pending	28a. Date of In (Month, i	njury Day Year)	28b. Time of Injury	28c. Injury Work			. Describe ha			
<u>0</u>	Attending r death. sctor: After by the fune	cati	2 Accident investigation inve	ation of he			M 10'	Yes 2□N	No				
DIVISION	1 the 1	ertification;	4 ☐ Homicide determin	286. Place of	Injury - At hor etc. (Specify	me, farm, str )	eet, factory, office		28f.	Location (St. City or Town			ral Route Number,
_	Hospital or 24 hours efter Funeral Direction in 1919 filled i	O	29a. Certifier 100 Certifying	Physician: To the be	st of my know	vledne death	accurred at the tim	e date and	f place, and	due to the ca	auco/c)	and manner as	stated
	To the Hospital within 24 hours e To the Funeral Completely filled	edicai	(Check only 2 Medical E	xaminer: On the basis and manner	s of examinati	ion and/or in	estigation, in my op	oinion, deat	h occurred a	at the time, da	ate and	place, and due	to the cause(s)
	To the within 2 To the complet	M	29b. Signature and title of certifier	11			29c. License	number		2	9d. Date	signed (Monti	n, Day, Year)
ł			× 51	11			D389	58		1	0/10	5/06	
	5		30. Name and address of a so	o completed cause of	of death (Item	23a) (Type,	Print)	_	00	1	ŧ	4 4 4 =	
			31. Date tiled (Month, Day, Year)	h didhu	208 strar's Signat	Lain	Print)  Highway	SW	Wes	Bun	W	MD 210	761
	Sta Registr		OCT 1 7 20	006 Age	saars signat	ui e	UV						
					J.S.	1220							

		-	For State Registrar	State	of Maryla		artment of H		d Mental Hy	giene	16	34743
	Physici		Decedent's Name (First, Midd		* .				2. Date of De Month	ath Day	Year	3. Time of Death
	/Medic	al	4a. Facility Name (If not institution		ara M. I	Dockery	4b. City, Town, or	r Location of D	Octobe	er 16, 20		2:00 A. M
	Examin	er	Silver Spring					Sprine			gomery	
	Funeral		5. Social Security Number	6. Sex 1 □ M 2√2 F	7. Age (In yr	s. last birthday)	If Under 1 Year Months Days	If Under 24 I	Hrs. 8. Date of Bir Vin. (Month, Da	th y, Year)	9. Birthplac Country	ce (State or Foreign
	Director	-	228-56-0022 Usual Residence of Decedent		68	3 115.			Mar. 7	, 1938	Virgin	nia
	ryland how		10a. State 10b. Count	у	10c. (	City, Town or L					10d	J. Inside City Limits
	8a-f s	Director		gomery			Silver	Spring		10 000 11		1∑Yes 2 No
	with t	Dir	10e. Street and Number 2601 Bel Pre	Road			10f. Zip Code	20906		10g. Citizen of V USA	vnat Country	y r
	death	nera	11. Marital Status		ecedent Ever in	U.S. 13.			? (Specify Yes or No uerto Rican, etc.)		e - American	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural; or items 23a or 28a-f show any injury or other traumatic event, the Modical Examinar must be notified at another.	by Funeral	1 Never Married 2 Ma	rried 1 TYes	2 ∑No 3ive		1 ☐ Yes 2 ☑ No	Specify:	ueno rican, ec.)		ck, White, etc v: Blac	
Ö	turai'	ed b	3 🔀 Widowed 4 □ Divorce	int's Education		16a. Dece	dent's Usual Occup	pation		16b. Kind of Bu		
215	thin 72 en "na Madi	Completed	(Specify only high Elementary/Secondary (0-12)	est grade complete	(1-4or 5+)	(Give	kind of work done DO NOT use retired	during most of d)	working			
2	led wit lygien her th		8	(		Singe	er	10 Mathada	Name (First, Middle	Enterta		t
Maryland 21215-0036	d be fi	To Be	17. Father's Name (First, Middle		y Caldw	æll			thaney Tur		18)	
ary	shoul and Ma s marl	F	19a. Informant's Name/Relation		2		ng Address (Street		r Rural Route Numb		State, Zip C	<sup>Code)</sup> 22408
N.	and 2 ealth an 27 i		Jerry McCormi	.ck - Son	- I an	The second second		a Court	, Frederi			
lore	iges 1 at of H if ite		20a. Method of Disposition 1 ⊠Burial 2 ☐ Cremation		1		osition (Name of matory or other place	D110-	Date -20-06	20c. Location -		
Baltimore,	oit. Pa entmer ortant injury		4 □Donation 5 □ Other (		H	armony	Memorial  2. Name and Addre	ss of Facility	Beall Fur	Landove		ryland
Ba	Daparti Importanti any ir		• (/	1670	Feal				n Hwy., Bo			20715
			23a. Part1. Enter the disease, shock, or heart failure. Li	or complications tha st only one cause or	t caused the de n each line.	eath. Do not en	ter the mode of dyin	ng, such as car	rdiac or respiratory a	rrest,	lr Ir	Approximate nterval Between Onset and Death
	Pnysician /Medical		tmmediate Cause (Final disease or condition resulting in death)				yhdrome					purs
	Examiner				o (or as a cons abetes 1		C C				Wz	ars
		ner	Requestivally full conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	0.	o (or as a cons						-	CILITY
	ecuted and transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	C. Duni	o (or as a cons	aguana af):						
8760,	icate be executed physician and s the burial-transit	ical E	,	500	O (O) as a cons	aquanca on).						
Ö	tificate g phys as the	ledic		0.							II.	
Вох	death certificate be executed e attending physician and nd for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?		outcome of preg		☐Ectopic pregnancy	y			te of delivery	ray Year
	at the dea by the at tached fo	ysici	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4□Pre 9□Uni	gnant at time o known	f death 5 (	Other (specify) _			1410		uy rour
P.O.	iaw requires that the as been signed by th 2 should be detache	by Ph	Part II. Other significant condi	tions contributing to	death but not r	esulting in the t	underlying cause giv	ren in Part I.	23e. Did t	obacco use cont	ribute to the	cause of death?
ords	w requires been sig should b		Hyper	tensive h	eart di	sease			10	Yes 2 ☐ No	3 Probab	oly 4 ⊠Unknown
Records,	e law r has be je 2 sh	Completed							24a. Was	psy	prior to comp	y findings available pletion of cause of
alF	Th ate pag		05 Mas and anti-						1 □ Yes	2 🐼 No	death? 1 🗌 Yes 2	□ No
Vital	Physician: r this certific ral director,	To Be	25. Was case referred to medic examiner? 1 ☐ Yes 2 ☐ No	Hospital:	☐Inpatient 2	☐ ER/Outpatie	nt 3 DOA Oth	or.	Death (Check only)		er (Specify)	
n of	ding Ph h. After th funeral		27. Manner of Death 15€ Natural 5 ☐ Pend	28a. Da	te of Injury onth, Day Year)	28b. Time o				how injury occur		
Division	r Attending er death. rector: After by the fune	cati	2 Accident inves	stigation d not be	no of loius. At	home form of		Yes 2 □No		Street and Numb	or or Pural I	Pouto Number
Divi		Certification	4 ☐ Homicide dete	mined 289. Pla	Iding, etc. (Spe	cify)	reet, factory, office		City or To		er or nurair	Houle Number,
	Hospita 24 hours Funeral	edical C		al Examiner: On the					place, and due to the occurred at the time,			
	To the within To the comple	Me	29b. Signature and title of certif				29c. Licens	se number		29d. Date signe		
) (			Since	26_			DI	487	6	10.1	6.01	5
44	۲ /		30. Name and address of person						7. 7	2225		
	Sta	ate	Suresh C. G 31. Date filed (Month, Day, Yea	upte MD,	4 / U TRA: . Registrar's Şiç	ndolph gnature	ka., Rock	ville,	Maryland	20852		
4	Regist		OCT 1 7 2	006	. Registrar's Sig	April	V					

			For State Registrar			of Mary					ealth a			Reg. No.	2006	5 3	4744
*	Physici	an	1. Decedent's Name (First,										2. Date of De Month	Day	Yea	r	Time of Death
V	/Media	al	Jewell  4a. Fecility Name (If not ins	B.	Fair	umber)	· · · · · · · · · · · · · · · · · · ·		4b. City	Town or	Location of	of Death	Octobe:		200 County of De		8:50 a <sup>M</sup>
	Examir	ıer	Southern M							into		or Doutin			cince		ges
	Funeral		5. Social Security Number		6. Sex		yrs. last birth	day)	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir			Birthplace	State or Foreign
	Director		579-88-3114		1 □ M 2 🖾 F	4.4	¥ Yı	rs.	MOTOTO	Days	riguis	IVIIII,	8. Date of Bir (Month, Da Oct.29	,196	L Wa	shing	gton,D.C.
	and wc		Usual Residence of Deced	ounty		10	c. City, Town	or Lo	cation							10d. In	side City Limits
	Mary I eh	ţ	North Carolina				Charle	)tt	e.							1	Yes 2 No
	or 28e	Director	10e. Street and Number				011012		10f. Zip	Code				10g. Citiz	en of What	Country?	
	er deeth with the Marylan Iteme 23a or 28a-f ehow car must be notified at		7638 Wallace	Ln	•				28	212				Un:	ited S	tates	5
	er der	Funerai	11. Marital Status	<b>-</b>	Armed I		r in U.S.	13. V	Vas Deced Yes, spec	lent of Hi offy Cuba	spanic Ori n, Mexicar	gin? (Sp n, Puerto	ecify Yes or No Rican, etc.)	- 1	<ol> <li>Race - Ar Black, Wi</li> </ol>		dian,
36	rei', or	by F	1 ☐ Never Married 25 3 ☐ Widowed 4 ☐ Dir		ed 1 Yes If Yes, 0 Year or	2 K∑ No Sive Dates:	1	1	☐ Yes 2	28 No	Specify:				Specify: B	lack	
21215-0036	72 hours after deeth with the Maryland "naturel", or iteme 23a or 28a-f ehow dical Examinar mat be notified at				's Education		16a. C	Deced	lent's Usua	I Occupa	ation			16b. Kir	d of Busines	ss/Indu <i>s</i> try	,
218	C 3	Completed	Elementary/Secondary (		t grade completed College	(1-4or 5+)		life. [	kina of woi DO NOT us tract	e retired SDE	uring mos cial:	rorwork ist	ing	Gove	ernmen	t	
	77		12 17. Father's Name (First, M	dialate (	l nath								. (Cina Middle				
Maryland	a ta b	Be	James Herbe		Last/								e (First, Middle, Johnson		<i>Sum</i> ame)		
Ž	d 2 should th and Men 7 ie marke treumatic	၉	19a. Informant's Name/Re		nip (Type, Print)		19b. I	Mailin	g Address	(Street a			al Route Numbe		Town, State	, Zip Code	a)
	od 2 lith a 27 ic		Eddie Fair	/ s	pouse		763	38	Walla	ce I	n. Cl	harl	otte, N	.c.	28212		
ore	OF THE STATE OF TH		20a. Method of Disposition 1 ☐ Burial 2 ☑ Crem	-	•	1	Ob. Place of D	Dispos		ne of	e)		Date	20c. Loc	ation - City		
Ë	Peges Iment of it tant: If its jury or o		4 Donation 5 DO	ther (Sp	oecity)	I State	Metropo						18,2006				
Baltimore,	permit. Pege Department of Important: If eny injury or once.		21. Signature of Funeral S	ervice L	i i nsee	NOI	UFS	22	Alexa 5538	d Addres inder Mar l	boro	PPF	Funera e/Fores	tvil	nes, P	:A·20	0747
		`.	23a. Part . Enter the diseashock, or heart failure	e, or List	complications that	caused the each line.	death. Do no	ot ente	er the mod	e of dying	g, such as			48		Inter	oximate val Between
	Pnysician		Immediate Cause (Final disease or condition resulting in death)		_ a		M	d	asla	rle	21	ne	ust	AN	Les	Am C	et and Death
	/Medical Examiner		resulting in death)		Due to	o (or as a co	nsequence of	f):									
		ē	Sequentially list conditions if any, leading to immediat	e	b. — Due to	o (or as a co	nsequence of	):								-	
	cuted	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events	1	G												
, 0	be executed sicien and burial-transit		resulting in death) Last		Due to	o (or as a co	nsequence of	):									
8760	icate be exi physicien a s the burial:	dicai			d												
9 x	death certificate e ettending physid for use as the	/Med	IF FEMALE:		23c. If yes, o	utcome of p	regnancy							2	2d Date of d	lolivon	
Вох	death e etter d for u	Physician/M	in the past 12 months 1 ☐ Yes 2 ☐ No			birth 2 in	Fetal death of death		Ectopic pro					-	3d. Date of d Month	Day	Year
P.O.	y th	hys	9 □ Unknown		9□ Unk	nown											
	S 5 6	ЬγР	Part II. Other significant co	onditio	ns contributing to	death but no	ot resulting in t	the un	derlying ca	ause give	n in Part I.		23e. Did to	obacco us	e contribute	to the cau	ise of death?
ord	w requir been si should I	ted	1)-11										101	/es 2□	]No 3□1	Probably	4 Junknown
Records,	e law has b	Completed	INEUN	0-									24a. Was autop		prior te	o completi	ndings available on of cause of
al	n: The lifcete ha	O O	25. Was case referred to n										1 ☐ Yes	2 340	death? 1 ☐ Ye	s 2 l	No
Ž	Physicien: This certificeral director, p	To Be	examiner?	edicai	Hospital:	Inpatient	2 ER/Outp	nationt	3 □ DO	Othe			n <i>Check only o</i> me 5□Resid		□Other (Cr	200/64	
J Of	tending Physicien: Jeeth. tor: After this certific the funeral director.		27. Manner of Death	O	28a. Date	of Injury	28b. Tir		_	Bc. Injury Work			28d. Describe h			эөспу)	
Sior	Attending r deeth.	atic	2 Accident	Pending	ation	, 64, 76	G.7 IIII	uty	М		/es 2 □ l	No	-				
Division of Vital	or Al	Certification:		Could n determi	ned 289. Plac	e of Injury - ding, etc. (S	At home, fam pecify)	n, stre	et, factory	, office			28f. Location (5 City or Tox		Number or I	Rural Rout	te Number,
	To the Hospital or At within 24 hours effer of To the Funeral Directompletely filled in by	edicai C	29a. Certifier 1 Me	ortifying odical E	g Physician: To t Examina : and ma	is of exa	y knowledge, amination and/	or inv	occurred a estigation,	at the tim in my op	e, date an inion, dea	d place, th occurr	and due to the red at the time,	date and	ind manner of	as stated. ue to the c	ause(s)
	To the Within To the	Me.	29b. Signature and title of	certific	1	)			29c	License					signed (Mo		
)	10	ř	1		179	1			5	04	150	4	6	Sele	Ben,	12/	6.6
d	48)		30. Name and address of p	ersen v	who complete car	use of death	(Item 23a) (T	ype, f		2.1	1.0.	500	thy my	^		-	
	Sta	te	31. Date filed (Month, Day,		0 2.	Registrar's	Signature		100	.711	ve7.	16	Jay	2 ر	070	2	
	Registr		OCT 1	9 2	006	Registrar's	Signature	754									

		1	For State Registrar	State of Marylan		artment of Heal		tal Hygier	211116	34745
	A)	-	1. Decedent's Name (First, Middle, Last	)					Day Year	3. Time of Death
	Physicia Medic/	al		John Francis	Fay I				4, 2006	10:50 A.M
	Examin	er	4a. Facility Name (If not institution, give			4b. City, Town, or Loca	ation of Death		4c. County of Death	
	-		6700 Willow Cree  5. Social Security Number 6. Se		ast hirthday)	Bowie If Under 1 Year   If U	Inder 24 Hrs. 8, [	Date of Birth	Prince Ge	
	uneral irector			M 2□F 59	Yrs.		ours Min. (	Month, Day, Ye in. 28,1		place (State or Foreign unity) yland
pur	*	}-	Usual Residence of Decedent  10a. State 10b. County	10c. City	, Town or Lo	ecation				10d. Inside City Limits
Maryli	1 sho	5	MD. Prince (	Georges	Bowie					XXYes 2 ☐ No
the	28s-	Director	10e. Street and Number			10f. Zip Code		10g.	Citizen of What Co	untry?
with	38 or	O	6700 Willow Creel	Road		2072	20	Ţ	JSA	
within 72 hours after death with the Maryland	Department of result and workers bygener, or thems 23a or 28a-1 show morticated if it is marked other than "natural", or freen 27 is marked other than "natural", or the mortical Examinar must be notified at once.	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☑ Married	12. Was Decedent Ever in U. Armed Forces? 1∑Yes 2 ☐ No If Yes, Give	1	Was Decedent of Hispan If Yes, specify Cuban, Mo 1 ☐ Yes 230 No Sp	nic Origin? (Specify exican, Puerto Rica pecify:	Yes or No- n, etc.)	14. Race - Amer Black, White Specify: Wh:	o, etc.
72 hours	natural Jical Ex	Completed b	3 Widowed 4 Divorced  15. Decedent's Ed (Specify only highest grav	Year or Dates: ucation de completed)	(Give	dent's Usual Occupation kind of work done during	g most of working	16b	. Kind of Business/l	ndustry
ithin a	L M	E G	Etementary/Secondary (0-12)	College (1-4or 5+) 4		DO NOT use retired)  President-M	Marketing		Consulting	9
	ther i	ပ္သ	17. Father's Name (First, Middle, Last)	4	1200		Mother's Name (Fil	rst, Middle, Maid	den Sumame)	<u>-</u>
d be	c eve	To Be		John Francis F	ay, Jr		E	velyn Be	erberic	
nd 2 should be filed within 72 hours af	27 is mar traumat	-	19a. Informant's Name/Relationship (7) Patricia W. Fay			ng Address (Street and I				
Dallinore, permit. Pages 1 ar	nt: if item y or other		20a. Method of Disposition  1 ☐ Burial 2 ☒ Cremation 3 ☐  4 ☐ Donation 5 ☐ Other (Specify	Removal from State	emetery, cre	osition (Name of matory or other place) Ltan Cremato	Date Ory 10-18-0	16	: Location - City or exandria,	
Dalli. F	importar any injur		21. Signature of Funeral Sance ic		Commence of the Commence of th	2. Name and Address of 6512 N.W. (	Facility Bea.		ral Home e, Maryla	nd 20715
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	dications that caused the deat	h. Do not en					Approximate Interval Between
/[\	hysician and prize fransit the burial-transit	icai Examiner	tmmediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, Tary leading to introduce cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Esophageal Due to (or as a consect b. Due to (or as a consect c. Due to (or as a consect	uence of):					
ntificate	ng phys as the		IE EEMALE.	u				- X		
.O. DOX of	by the attending p tached for use as f	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnant Live birth 2 ☐ Feta 4 ☐ Pregnant at time of continuous Unknown	if death 3	Ectopic pregnancy Other (specify)		<del></del>	23d. Date of det Month	ivery Day Year
<b>₽</b> ፮	gned be de	þ	Part II. Other significant conditions o	ontributing to death but not res	ulting in the	underlying cause given in	Part I.			the cause of death?
r e	sete has been si page 2 should	Completed						24a. Was an autopsy performed	prior to death?	utopsy findings available completion of cause of
	certificel rector, p	Be C	25. Was case referred to medical			26	Place of Death C			
OT VITA Physician:	S 0	To	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1   Inpatient 2	ER/Outpatie				e 6 □Other (Spe	cify)
	ith. :: After th e funeral		27. Manner of Death 1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time tnjury	Work?	28d	. Describe how	injury occurred	
_ =	after death   Director: / d in by the f	Certification:	3 Suicide 6 Could not b 4 Homicide determined	28e. Place of Injury - At h building, etc. (Speci		treet, factory, office	28f.	Location (Stree City or Town, S	et and Number or Ri State)	ural Route Number,
L e Hospitai	within 24 hours af To the Funeral D completely filled in	Medical C	29a. Certifier 1 Certifying Ph (Check only 2 Medical Exar	ysician: To the best of my kn niner: On the basis of examin and manner stated.	owledge, dea ation and/or i	th occurred at the time, on the stigation, in my opinion	date and place, and on, death occurred	due to the caus at the time, date	se(s) and manner as and place, and due	s stated. to the cause(s)
To th		Me	29b. Signature and title of certifier	reeen		29c. License nu D23743			Date signed (Mont October 16	
-W	10		30. Name and address of person who Martin Weltz MD				reenhelt	Marvla	nd 20770	
8	C	ate	31. Date filed (Month, Day, Year)	32. Registrar's Sign	ature 🌶	CT DITAC, G	-concert,	• • • • • • • • • • • • • • • • • • •	20770	
÷	Regist		OCT 1 7 2006	32. Registrar's Sign	Sport	v .				

		4	State of N	Maryland / Department of Health and M	lental Hygien	e2006	34746
			Registrar  1. Decedent's Name (First, Middle, Last)	Certificate of Death	Reg. N		3. Time of Death
	Physicia		ARGATHIA	GIBBS	Month P	3 Year	a a a i summ
	/Medic Examin		4a Facility Name (If not institution, give street and number			c. County of Death	i l
	Funeval		5. Social Security Number 6. Sex 7.	Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	8. Date of Birth	9. Birth	ester place (State or Foreign
	Funeral Director		218-16-8721 10M 2/AF	83 Yrs. Months Days Hours Min.	(Month, Day, Year	- 23 MAR	YLAND
	land ow		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Location			10d. Inside City Limits
:	e-f eh	ctor	Md Worcester	SNOW HILL			1 □Yes 2 XNo
	be filed within 72 hours after death with the Maryland Hygiene. Hygiene. Ad other than "naturel", or items 23s or 28e-f show event, the Madical Extrainer traint to notified at	Funeral Director	10e. Street and Number	LL Road 21863	10g. C	itizen of What Cou	intry?
	death ms 23	neral	11. Marital Status 12. Was Decede Armed Force	nt Ever in U.S. 13. Was Decedent of Hispanic Origin? (Spe	ecify Yes or No-	14. Race - Ameri Black, White	
	hours after turel', or Ite	by Fui	1 Never Married 2 Married 1 Yes 2	No 1 ☐ Yes 2 No Specify:	ritoan, oto.,	Specify: 2	ACV
2-003p	2 hours		3 ☐ Widowed 4 ☐ Divorced Year or Date  15. Decedent's Education	16a. Decedent's Usual Occupation		Kind of Business/I	ndustry
בן בו	within 72 ene. than "na he Madis	Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4)	(Give kind of work done during most of work life. DO NOT use retired)  HOUSEWIFE		lomemo	King
	filed w Hygier other th	Co	17. Father's Name (First, Middle, Last)		e (First, Middle, Maide		CIVI 0
⊆ .	should be nd Mental marked c matic eve	To Be	John T. Waters	Maryt	tester	Steve	nson
la⊓ J	E e a .		19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Run			_
	t Health Item 27 other tr		Jesse C. Gibbs Chusb 20a. Method of Disposition	20b. Place of Disposition (Name of		Location - City or T	
Ē	Pages nent of int: If It iry or o	-	1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)	George town Cem. 10/	21/06 Si	ion Hil	1, Md
Baltimore,	permit. Pages Department of Importent: If II any injury or o		21, Signature 1 Fine al Service Licensee	22. Name and Address of Facility 9 Bennie Smith FUNERAL HOME	21/06 SA 17 W. ISAR SALISBURY	, maryla	HEET 21801
			23a. Part1. Enter the disease, or complications that cau shock, or heart failure. List only one cause on eac	sed the death. Do not enter the mode of dying, such as cardiac	or respiratory arrest,		Approximate Interval Between
F	Physician		Immediate Cause (Final disease or condition a	onary ATheroscleros	S1'S		Onset and Death
	/Medical Examiner		Due to (or	as a consequence of):			
	D =	ner	cause. Enter Underlying	as a consequence of).			
	and I-trans	Examine	Cause (Disease or injury that initiated events c.	as a consequence of):			
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89 )	artificating physical partitions and physical ph	Medi	IF FEMALE:				
Bô	that the death certifi ed by the attending detached for use as	Physician/Me		me of pregnancy  ∩ 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  t at time of death 5 ☐ Other (specify)		23d. Date of deli- Month	Day Year
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ls,	w requires that been signed be should be det	ρ	Part II. Other significant conditions contributing to deal	h but not resulting in the underlying cause given in Part I.	1 Tes		the cause of death?
Cor	w requ	Completed			24a. Was an	24b. Were au	topsy findings available
Be	The law sete has page 2 s	dmo:			autopsy performed?	death?	ompletion of cause of 2□ No
/ita	ysiclen: Th is certificete director, pag	Be	25. Was case referred to medical examiner?	Othor	th (Check only one)		
ð	Physic r this c aral dir	. To	27. Manner of Death 28a. Date of	Injury 28b. Time of 28c. Injury at	ome 5 Residence 28d. Describe how in		erfy)
ion	ath. or: Afte	atio	2 Accident investigation	Day Year) Injury Work? M 1 ☐ Yes 2 ☐ No			
Division of Vital Records, P.O. Box	To the Hospital or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certifical completely filled in by the tuneral director.	Certification:	3 Suicide 6 Could not be determined 28e. Place o building	Injury - At home, farm, street, factory, office, etc. (Specify)	28f. Location (Street City or Town, Sta		ral Route Number,
	ospital hours unerel ly filled		29a. Certifier  (Check only  2 Medical Examiner: On the bas	est of my knowledge, death occurred at the time, date and place, is of examination and/or investigation, in my opinion, death occur	and due to the cause	(s) and manner as	stated.
	the H thin 24 the Fi mplete	Medical	and manne  29b. Signal and title of certifier	r stated.  29c. License number		Date signed (Month	
)	1358)		Bank MD (SORAD	R. BARAL) D54422		10-16-	
	B		30. Name and address of person who empleted cause		910=1		
	14	ate	31. Date filed (Month, Day, Year) 32. Beg	jistrar's Signature	21851		
	Sta Regist		OCT 18 2006	we It Sparke			

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes 34747 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Barrington R. Greene 2006 October 0 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Prince George's Hospital Prince George's Chever1v If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1**X** M 2□ F Vrs 577-48-7403 69 6, 1937 Sep. Wash. DC Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 Yes 2 No DC Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4712 Blaine St., NE 20019 United States 12. Was Decedent Ever in U.S. Armed Forces? 1∑Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 27 No Specify: Specify: Black 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Government Printing Elementary/Secondary (0-12) College (1-4or 5+) 12th Pressman 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Nathaniel Blakely Beatrice R. Greene 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia M. Greene/Daughter 6205 - 86th Ave., Hyattsville, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Ft. Lincoln Cemetery 10/18/2006 Brentwood, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stewart Funeral Home 4001 Benning Rd., NE Wash., DC 20019 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Atherosclerotic Heart Disease

Due to (or as a consequence of): Approximate Interval Between Onset and Death Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Que to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Atrial Fibrillation 1 Yes 2 No 3 Probably 4 Munknown 24b. Were autopsy findings available prior to completion of cause of death? End Stage Renal Disease 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 Yes 2 XNo 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2√☐ No 2 ☑ ER/Outpatient 3 DOA 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Matural 2 Accident 5 Pending Injury 1 Tes 2 No investigation 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) mo 30307

or Attending Physician: The law requires that the death certificate be executed as the burialattending physicien ō detached this After within 24 hours aftar death.

To the Funeral Director: A completely filled in by the fu

**Physician** 

/Medical

Examiner

**Funeral** 

Director

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Items 23a

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permit. Pages 1 end 2 should be filed within Depertment of Health and Mental Hygiane. Important: if Item 27 is marked other ther eny injury or other traumatic event, the Manca.

**Physician** /Medical

Examiner

death

Pages 1 end 2 should be filed within 72 hours after

Baltimore, Maryland 21215-0036

P.O. Box 68760

Division of Vital Records,

Director

Funeral

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Completed

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Physician/Medical

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Certification: To

Medical

injury or other traumatic event, the Medical Examiner must be notified at

State

Doris Pablo Bustos, M.D. 31. Date filed (Month, Day, Year)
OCT 1 7 2006

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1160 Varnum St., NE #213, Wash., DC 32. Registrar's Signature

DHMH 17 Rev 1/2001

Registrar

			ricase	Obstact Manager			•	•	
			1 _ For State	State of Maryland				2000	01710
			Registrar		Certific	ate of Death		eg. NoZ U U 6	34/48
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	ylan		10a. State 10b. County	10c. City, T	Town or Location			,	10d. Inside City Limits
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	leath	Funerai	11. Marital Status	12. Was Decedent Ever in U.S.	13. Was D	ecedent of Hispanic Origin? (S	pecify Yes or No-	14. Race - Ame	erican Indian.
_	it of	Ę	1 Never Married 2 Married	Armed Forces?	If Yes,	ecedent of Hispanic Origin? (S specify Cuban, Mexican, Puert	o Rican, etc.)	Black, Whi	
ž	as	þ	3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 MNo If Yes, Give Year or Dates:	1 □ Ye	s 2 No Specify:		Specify: 73	lack
ş	ture sture	ed	15. Decedent's E	ducation	16a. Decedent's	Usual Occupation		16b. Kind of Business	
1215-0036	7 0	Completed	(Specify only highest gra		(Give kind o	f work done during most of wor T use retired)	rking	^	,
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ق	od in the control of	) Be	· )	$C_{-}$	-111:0	Maria	1=		and and
2	should be filed withir ind Mental Hygiene.  marked other than umatic event, Italia	၉	19a. Informant's Name/Relationship (	Tuna Print)	10h Mailing Ada	ress (Street and Number or Ru	- C.		5000COIN
Maryland	2 6 6 7		Manage Call		IN I MINT	21 2:14	1	, City of Town, State,	Zip Code)
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altimore,	0 0		1 Burial 2 Cremation 3	Removal from State	etery, crematory	or other place)	Date	20c. Location - Oity or	Town, State
<u>E</u>	permit. Pag Department important: I eny injury o		4 ☐ Donation 5 ☐ Other (Specif		URRICH	UN 10-	19-2006	C'INTON.	MARYLAND
<u></u>	permit. Depart Import eny inj once.		21. Signature of Funeral Service Licer	1598	22. Nam	e and Address of Facility	Inns Fu	uceal Hom	E P.A.
m	89 = 9		Zly &	19	11 200	OS ACUASCO.	Road Ag	UASCO MARU	IAND 20608
			23a. Part1. Enter the disease, or com shock, or hear failure. List only	plications that caused the death.					Approximate Interval Between
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	nsit	듩	cause. Enter Underlying Cause (Disease or injury	Acut	MYOCARDI	L INFARCTION			Hours
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	The law requires thet the death certificate die has been signed by the ettending phy page 2 should be deteched for use as the	Physician/Med	IF FEMALE:	23c. If ves, outcome of pregnance	v			224 8-1	P
Box	etter for u	ian	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 ☐ Fetal de 4 ☐ Pregnant at time of deat	eath 3⊟Ectop	ic pregnancy		23d. Date of de Month	Day Year
o	uires thet the de signed by the e id be deteched f	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown	in 5□ Otne	r (specify)			
<u> </u>	nd by detec	윤	Part II. Other significant conditions of	contributing to death but not regulting	ng in the underly	ng cause gwen in Part I	23e Did to	bacco use contribute to	o the cause of death?
Vital Records,	res t signe be d	Ď	Tarrii olioi olgiiiloani oolianoiis	contributing to death but not resulti	ing in the dilderly	ng cause given in Faits.			
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ပ္ပ	has bu	pie					24a. Was a autops	an 24b. Were a	utopsy findings available completion of cause of
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ā	Attending Physician: r death. sctor: After this certifice by the funeral director, p	Be	25. Was case referred to medical			26. Place of Dea	ath (Check only or	*	
	aysic lis ce dire	To	examiner? CASE 1 Yes 2 No CLINE	Hospital: 1 Inpatient 2 ☐ ER	VOutpatient 3[	DOA Other: 4 Nursing H	lome 5 Reside	ence 6 Other (Spe	ecify)
Division of	ter th		27. Manner of Death	28a. Oate of Injury (Month, Day Year)	8b. Time of Injury	28c. Injury at Work?	28d. Describe h	ow injury occurred	
<u>ō</u>	ath. r: At	atlo	1 Natural 5 ☐ Pending 2 ☐ Accident investigatio		М	1 ☐ Yes 2 ☐ No			
S	Atte	ific	3 ☐ Suicide 6 ☐ Could not b	286. Place of Injury - At nome	e, farm, street, fa	ctory, office	28f. Location (S	treet and Number or R	ural Route Number,
ō	ai or A s after of Dire	Certification:	4 🗔 (10.110.00	building, etc. (Specify)			City or Tow	n, Siale)	
	hour hour ner y fille		29a. Certifier 1 Certifying Pt	nysician: To the best of my knowle	edge, death occu	rred at the time, date and place	, and due to the c	ause(s) and manner a	s stated.
	To the Hospital or Attending Physician: The within 24 hours after death.  To the Funerel Director: After this certificete ha completely filled in by the funeral director, page	Medical	one)	miner: On the basis of examination and manner stated.	n and/or investig	ition, in my opinion, death occi	irred at the time, d	ate and place, and du	e to the cause(s)
	Vith To t	Σ	29b. Signature and title of certifier	ESTERN	AT	29c. License number		9d. Date signed (Mon	
)			1 and	MD		D0065885		valu las	
	9 -		30. Name and address of person who	completed cause of death (Item 2)	3a) (Type, Print)			- 4/4/04	
	113		PIETER ESTI	CRIAT , MD 2550	O Point	DOGZ662 cokout Road Le	ward to	WW. Maxila	v/20650
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signatur	° /	M.		- July	
	Regist	rar	OCT 1.8	200\$ Steen A	cr syper				

DHMH 17 Rev 1/2001

ERNEST CASMIRI GOODWIN

State of Maryland / Department of Health and Mental Hygiene-State Registrar 23a per Dr/10-23-06/wichd/d1Gertificate of Death Amend item -Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** enr CE /Medical Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hospice at SUISBURY
If Under 1 Year If Under 24 Hrs. WILLOMICO the 9. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, **Funeral** Year) Days Months Hours Min 1 M 2□ F 8 7-12-4837 07 Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits ir than "natural", or Itama 23a or 28a-f ahov the Medical Examiner must be notified at 1 Yes 2 No 115 bury Directo WICOMICO 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 WAY DRIVE 21804 death Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ZWes 2 ☐ No IJYes, Give 14. Race - American Indian. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0036 Specify: 3 Widowed 4 Divorced BIACK 927819942 - IC JAN 1846 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry other then Elementary/Secondary (0-12) College (1-4or 5+) 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Sk. 12 should be fill and Mental H Is marked ott Be မှ 19a. Informant's Name/Relationship (Type) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Depertment of Health and Important: If Itam 27 Ian any injury or other traun 2006. 30420 Mallard DR. Dr. Robert A. Harleston (Brother) DELMAR, Md 20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State cometery, crematory prother place)
EASTERN SHARE
MALLAND VIETERS Com. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Bennie Smith FUNERAL Home 21. Signature of Funeral Service Licenses 917 W. Isabella St SALISBURY 791 mmie 21801 mel 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heer failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Pulmonary Fibrosis disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner The law requires that the death certificate be executed use as the burial-transit ettending physician and for use as the burial-trar resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE If yes, outcome of pregnancy 1□Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 Other (specify) P.O. | 9 Unknown 9 Unknown sete hes been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 2 No 1 Yes 1 Yes 2/2 No or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: npatient 1 ☐ Yes 2 No Certification: To 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this After thi 28a. Tate of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 28b. Time of Injury 1 Natural 2 Accident 5 Pending To the Hospital or Attendia within 24 hours after death. 7 To the Funeral Director: Al death. 1 Yes 2 No investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 3460-7>1425 30 Name a address of person who completed cause of death (Item 23a) (Type, Print) DASTAL JAMES W 31. Date filed (Month, Day, Year) 32. Registrar's Signature 1 8 2006 Registrar

**ORIGINAL** 

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene Frederick Horsley 1- For State Certificate of Death Registrar Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time of Death Physician/ Month Day October 22, 2006 Horslev 1435 hrs Medical Examiner Frederick c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Prince George's **Fairmont Heights** 1305 Oats Street If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9 Birthplace (State or Foreign 5. Social Security Number 6 Sex 7 Age (In vrs. last birthday) **Funeral** Hours Min Months Days Director 227-58-6876 Nov.15,1945 Virginia 60 1 **8 y**M 2 Usual Residence of Decedent 10d Inside City Limits 10c. City, Town or Location 10a State 10b County Yes 2 23a or 28a-f show notified at once. Maryland Prince George's Riverdale death with the Maryland Director 10g. Citizen of What Country? 10e. Street and Number 10f Zip Code 5507 Good Luck Road 20737 Funeral 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black or items must be White, etc. Armed Forces 1 Never Married 2 Married 2 % No Yes 1 Yes 2 No specify Specify Black after ( If Yes, Give Year Widowed 4 X Divorced à 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) is marked other than " atic event, the Medical Baltimore, MD 21215-0036 +01 Salesman es 1 and 2 should be filed withi of Health and Mental Hygiene If item 27 is marked other th Self-employed 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Be Frederick D. Horsley, Sr. Thelma D. Brown 19a Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rochanne Woodland/daughter 5507 Good Luck Rd. Riverdale, MD 20737 20b Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 20a Method of Disposition Date crematory or other place) 1 \* Burial 2 Cremation 3 Removal from State or other Department of Important: Cedar Hill Cemetery 10-28-2006 Donation 5 Other Specify Suitland, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Cedar Hill FH 4111 PA Ave. 23a. Part I. Enter the disease or complication M01374 Suitland.MD 20746 or complications that caused the leath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear Approximate Interval Between Onset and Physician failure. List only one cause on each line /Medical Death Hypertensive atherosclerotic cardiovascular disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Examiner if any, leading to immediate Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Physician/Medical X UNPENDED AMENDED #23a,27,perME,g861,11/2/06 TT physician Division of Vital Records, P.O. Box 68760, 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 3b. Was decedent pregnant in the 3 Ectopic pregnancy Year Live birth Fetal death Month Day 2 past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 No 9 Unknown Unknown 23e Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Yes 2 No 3 Probably 4 ✔ Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? this certificate ✓ Yes 2 1 🗸 Yes 26 Place of Death (Check only one) 25. Was case referred to medical Be Other<sub>4</sub> Hospital: 1 examiner? Inpatient 2 ER/Outpatient 3 Nursing Home 5 Residence 6 V Other: Scene 1 🗸 Yes ٩ 2 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Funeral Director: After Certification: 1 X Natural 1 Yes 2 No 5 Pending 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be or Town, State) determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place and due to the cause(s) To the and manner stated 29c. License number 29d Date signed (Month, Day, Year) 29b. Signature and title of certifier O.C.M.E October 23, 2006 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Carol Allan, MD Assistant Medical Examiner

State

Registrar's Signature

Registrar

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

		Redistrar	Certificate of Death		Reg. No.	2006 31.75
Plfysicia Medical Exami	ner	1. Decedent's Name (First, Middle,Last) SEAMUS J.	HING	Mor Oct	ober 10, 2006	Year 2025 hrs
		4a. Facility Name (if not institution, give street and number)  Prince George's Hospital Center	4b. City, Town, or Loca Cheverly	ation of Death		ounty of Death
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs 244–29–4579 1 XM 2 F 28	Months Days	Hours Min.	ate of Birth(MM/DD	9. Birthplace (State or Foreigh WASHINGTON County)
any	-	Usual Residence of Decedent  10a State 10b. County 10c. C	City, Town or Location			10d Inside City Limits
ž ,			SHINGTON			1 X Yes 2 No
Maryland 28a-f show d at once.	Director	10e. Street and Number	10f Zip Code		10g. Citizer	of What Country?
th the Maryland 23a or 28a-f sho		4921 J STREET N.E. #24	20002			S.A.
215-0036 be filed within 72 hours after death with the Maryland ntal Hygiene rked other than "natural", or items 23a or 28a-f she ent, the Medical Examiner must be notified at once	Fune	11. Marital Status  1 X Never Married  2 Married  3 Widowed  4 Divorced or Dates:	If Yes, specify Cuban, Me	exican, Puerto Rican,	etc.)	. Race - American Indian, Black, White, etc.
ours afi atural'	d by	15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's Usual Occupation (	(Give kind of work do		d of Business/Industry
5-0036 led within 72 hours af Hygiene other than "matural the Medical Examin	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) 12th	during most of working life. DO  ELECTRICIAN AP		DI	RIVATE
5-00% led with tygiene other the Mec	Ë	17. Father's Name (First, Middle, Last)		Mother's Name (First,		
21215-0036 with be filed within 7 Mental Hygiene marked other than c event, the <u>Medica</u>	a	GLASCO GORHAM		IGELA HOOH		
MD d 2 shc lth and n 27 is	2	19a. Informant's Name/Relationship (Type, Print ) GLASCO GORHAM/FATHER	19b. Mailing Address (Street and 1603 EASTERN AV	E CAPITOL	HEIGHTS,	MD 20743
S L S L S L S L S L S L S L S L S L S L		1 X Burial 2 Cremation 3 Removal from State	Ob. Place of Disposition (Name of cemete crematory or other place)			cation - City or Town, State
Baltimo permit Page Department Important: injury or ott	- 5	4 Donation 5 Other Specify:  21 Signature of Funeral Service Licensee	IT. OLIVET CEMETERY  22 Name and Address of F			HINGTON, DC
Ba perm Depi		K-D. H-hall	22. Name and Address of F	JB JEN. R RD LAND	KINS FUNE OVER, MD	RAL HOME 20785
Physician /Medical		23a. Part I. Enter the disea e, or complications that caused the defailure. List only one i use on each line.	ath. Do not enter the mode of dying, such	ch as cardiac or respir	atory arrest, shock	Between Onset and
Examiner		Immediate Cause (Final disease or condition resulting in death)  a. Gunshot wound to all Due to (or as a consequence				Death
. **		Sequentially list conditions, b				
	Examiner	if any, leading to immediate Due to (or as a consequence cause. Enter Underlying Cause	e of):			
ed isit	Exan	events resulting in death) Last  Due to (or as a consequence	e of):			
execut an and al - tran		UNPENDED AMENDED			-	
760, ficate be exe g physician the burial	Med	IF FEMALE: 23c. If yes, outcome of pr			23d. [	Date of delivery
Sox 687 leath certifi e attending for use as t	cian/	23b. Was decedent pregnant in the past 12 months?  1 Live birth Pregnant at time of		Ectopic pregnancy	Me	onth Day Year
Box 68' e death certification attending ed for use as	Physician/Medical	1 Yes 2 No 9 Unknown 9 Unknown				
P.O. B that the d	by P	Part II. Other significant conditions contributing to death but no	ot resulting in the underlying cause giver			e contribute to the cause of death?
Division of Vital Records, P.O. tal or stending Physician: The law requires that the rs after death  "I Director: After this certificate has been signed by led in by the funeral director, page 2 should be detact	sted	ll <del></del>		<del></del>	4a. Was an	24b. Were autopsy findings available
e law r e has b	Completed				autopsy performed?	prior to completion of cause of death?
Vital Rec ysician: The his certificate	Be Co	25. Was case referred to medical		Death (Check only on	Yes 2 No	1 Yes 2 No
Vita hysici r this co	To B	examiner?  1 ✓ Yes 2 No Hospital: 1 ✓ Inpatient 2		ner Nursing Hom	- L.,	
n of Noting Ph		27. Manner of Death  1 Natural 5 Pending  28a. Date of Injury (Month, Day, Year) Oct 9, 2006	28b. Time of Injury 28c. Injury at 2302 hrs 1 Yes	Cubia	escribe how injury ect shot	occurred
Visior or Attent frer death Director:	ficati	2 Accident Investigation 28e Place of Injury - A	At home, farm, street, factory, office buildi		ocation (Street and	Number or Rural Route Number, City
Division Spital or Attent hours after death meral Director:	Certification:	4 Homicide determined (Specify) Alley		Frank	Town, State) S Tavern, 160	3 Eastern Ave. (Alley), Fairm
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - trans	Medical (	29a. Certifier (Check only 1 Certifying Physician: To the best of my know one) 2 Medical Examiner: On the basis of examination and manner stated				
FSFO	ž	29b. Signature and title of certifier	29c. License nu			te signed (Month, Day, Year)
		(de Marth	O.C.M.E	⊑. 	Octob	er 11, 2006
R (5)		Name and address of person who completed cause of death (If Zabiullah Ali, M.D. Assistant Medical Examin	,	ore, MD 21201		
	tate	31. Date filed (Month, Day Year)  OCT 1 8 2006	nature			
Regis	trar	OCT 1 8 2006 Keen A	- Marie			

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	1	For State Registrar	State of Ma	aryland		artment of i					06 0	34752
Physicia /Medic Examin	in al	1. Decedent's Name (First, Misdle, Last Facility Name (If not institution, give	e street and number)	Hìg	gir	S 4b. City, Town,	4		2. Date of Dea Month ICTOPLC	14 200 4c. County	O G	3. Time of Death 0204 M
Funeral Director		210 12 1012	ex 7. Ag	e (In yrs. las 84	t birthday) Yrs.	If Under 1 Year Months Days	If Under	24 Hrs. Min.	8. Date of Birth (Month, Day JAN 1,	2		ce (State or Foreign
death with the Maryland rme 23s or 28e-f ehow privat be notified at	_	Usual Residence of Decedent 10a. State 10b. County  MD TALBO3	1	10c. City,	Town or Lo						10d	I. Inside City Limits 1X Yes 2 □ No
with the	ā	10e. Street and Number	ı om			10f. Zip Code	21601			10g. Citizen of		/?
ING 21215-0036  be filed within 72 hours after death with the Marylan ital Hygiene. Ind other than "natural", or iteme 23a or 28e-f ehow ovent, tre Medical Examinar mant be notified at	by Fur	11. Marital Status  1 Never Married 2 Married  3 X Widowed 4 Divorced  15. Decedent's E	12. Was Decedent Armed Forces? 1	No	16a. Dece	Was Decedent of If Yes, specify Cul 1 ☐ Yes 2 X Note that Note I	Hispanic Ori pan, Mexicar Specify:			14. Rad Bla	USA  ce - American ck, White, etc  y: WHIT  dusiness/Indus	E.
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aryland 21 2 should be filed wi and Mental Hygien is marked other th	To Be Co	17. Father's Name (First, Middle, Last, MILLARD FAIRBAN	)			WOLLING!	18. Mothe		(First, Middle,	Maiden Sumai		u Ex
Aaryla 2 should 2 should 3 and Men 1 is marke reumatic		19a. Informant's Name/Relationship (	-			ng Address (Stree						ode)
altimore, Maryla mit. Pages 1 and 2 should partment of Health and Mer portent: If tem 27 is marke y injury or other traumatic gg.	ŀ	JOHN M. HIGGINS/  20a Method of Disposition  1 Burial 2 Cremation 3 C  4 Donation 5 Other (Special	Removal from State	сеп	ce of Disponetery, crei	osition (Name of matory or other pl	ace)	D	ate	20c. Location	- City or Town	
Baltimol permit. Pages Department of Important: If i any injury or o		21. Signature of Funeral Service Lice	nsee	F.S.P	22 ]	MEMORIAI 2. Name and Addi 3. PELLOWS, 200 S. H	ess of Facili	ty NBEI	N & NEW	NAM FUN	ERAL H	RYLAND OME PA
death certificate be executed hydrogram be executed be executed with the property of for use as the burial-transit	dical Examiner	23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	one cause on each li	a conseque	nce of):	lial In					l lr	oproximate Interval Between Onset and Death  Acces 5
P.O. BOX 68 that the death certifica ed by the ettending ph detached for use as it	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal d	eath 3	□Ectopic pregnan □ Other (specify)	су				ate of delivery onth D	ay Year
ecords, P.O. law requires that the as been signed by the 2 should be detache	٥	Part II. Other significant conditions	contributing to death t	out not result	ing in the u	ınderiying cause g	rven in Part	l.		obacco use cor res 2 🗆 No	tribute to the	cause of death?
Division of Vital Records, i or Attending Physician: The law requires t after death. Director: After this certificate has been signed in by the funeral director, page 2 should be a	Completed								24a. Was autop perfor	sy	Were autops prior to comp death? 1 Yes 2	y findings available bletion of cause of ☐ No
of Vital F Physician: Th r this certificete ral director, pag	Be	25. Was case referred to medical examiner?  1   Yes 2 □ No	Hospital:	ant 21ME	R/Outpatie	nt 3 DOA	thoc		n <i>(Check only o</i>		har (Snaciki)	
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Division attendes after death in Director: ad in by the	Certification:	3 Suicide 6 Could not be determined	288. Place of in	jury - At hom tc. (Specify)	ne, farm, st	reet, factory, office	9		28f. Location (S City or Tow		ber or Rural I	Route Number,
To the Hospital within 24 hours a To the Funerel Completely filled	Medical C	29a. Certifier 1 Certifying Pl (Check only one) 2 Medical Exa	hysician: To the best miner: On the basis of and manner s	of examination	ledge, deal	th occurred at the ovestigation, in my	time, date as opinion, des	nd place, a ath occurre	and due to the ded at the time, d	cause(s) and m date and place	anner as stat , and due to the	ed. he cause(s)
To th within To th comp	Me	29b. Signatura and title of certifier	MMP 4	ME	cy		1664	/		29d. Date sign		
-5-		30. me nd ad ress of person who	completed cause of	death (Item 2	23a) (Type	Print)	) 11	529		, 3		
Sta Registr		31. Date filed (Month, Day, Year)  OCT 1 7 2	32. Regist	rar's Signatu	re	fred a	g = 18	1-1				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Month **Physician** OCTOBER 13 2006 6:30 AM MARGARET S. HERSLOFF /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** EASTON TALBOT WILLIAM HILL MANOR If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In vrs. last birthday) DEC 11, 1 **Funeral** Months Days Hours Min 1 M 2 XF Yrs 1920 DELAWARE 85 Director 216-46-5536 Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b. County 28a-f ehow other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director TALBOT EASTON MD 10g, Citizen of What Country? 10f. Zip Code 10e. Street and Number or Itema 23a or 26988 PRESQUILLE ROAD 21601 TISA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. Black, White, etc. hours after 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: WHITE þ 3 Widowed 4 Divorced natural Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry d 2 should be filed withIn 7; ih and Mental Hygiene. 7 Is marked other than \*n. Elementary/Secondary (0-12) College (1-4or 5+) OWN HOME O HOMEMAKER 12 18. Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First Middle, Last) Be VIRGINIA MCCHESNEY HENRY P. SCOTT 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) s 1 and 2 s of Health an item 27 is 26398 PRESQUILLE ROAD, EASTON, MD 21601 LAURA EDDY/STEP-DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
important: If iten
any injury or oth 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 10/18/2006 OXFORD CEMETERY OXFORD, MARYLAND \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL 200 S. HARRISON ST EASTON, MD 21601 HELFENBEIN & NEWNAM FUNERAL HOME PA MERCERON JOHN R. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final ne Pnysician disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine the burial-transit requires that the death certificate be executed that initiated events and resulting in death) Last Due to (or as a consequence of) P.O. Box 68760 physician Physician/Medical use as attending F IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy Month Year in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) ed by the a detached f 2 🗹 No 9 Unknown 9 Tillnknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Records, 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? 2 No 1 TYes 2 🗇 Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 1 🔲 Inpatient 2 1 Yes 2 No 2 ER/Outpatient 3□ DQA 4 Jursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Hospital or Attending 1 Natural 5 Pending after death. М 1 ☐ Yes 2 ☐ No investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of pertifier 29c. License number MD 008 //5 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 WILLIAM H. WOOD, JR. M.D. 501 DUTCHMANS LANE, EASTON, MD 21601 31. Date filed (Month, Day, Year) 32 Registrar's Signature State OCT 1 6 2006 Registrar

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2 U U 6 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) October 15, 2006 **Physician** 8:55 PM Julius Hauser /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** 01ney Montgomery Montgomery General Hospital 8. Date of Birth (Month, Day, Year) Aug 17, 1914 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min Illinois 92 Director 350-10-3490 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location r than "naturel", or iteme 23s or 28s-f show the Medical Examinar must be notified at 1 Yes 2 No Directo MD Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20906 USA 3701 International Drive #446 Funeral 12. Was Decedenf Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, e filed within 72 hours after it Hygiene. other than "naturel", or ite 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2X No Specify: Ď 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Federal Government Efementary/Secondary (0-12) College (1-4or 5+) Food & Drug Admn. Officer 5+ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 end 2 should be fill ment of Heelth and Mental H tant: If Item 27 is marked off Morris Hauser Anna Diamond 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. fnformant's Name/Relationship (Type, Print) 5604 St. Albans Way Baltimore, MD 21212 Michael G. Hauser/son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Buriaf 2 X Cremation 3 ☐ Removal from State Department of Important: If any injury or once. Chesapeake Crematory | 10/18/06 Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signafurejof Funeral Service Going Home Cremation Service P.O. Box 784 MO1251Beverly L. Heckrotte, P.A. Clarksville, MD 21029 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final ATherosclerone **Physician** TENTIVE disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine attending physicien and for use as the burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 4 Pregnant at time of death 5 Other (specify) s certificate has been signed by the a lirector, page 2 should be detached to 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did fobacco use confribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No After this certification funeral director, I To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner 1 Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 ER/Outpatient 3 DOA 2 No 1 Inpatient 28a. Date of fnjury (Month, Day Year) 28c. Injury af Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification; Injury 1 ANatural 5 Pending 24 hours after death.

Funeral Director: Al м 1 Tes 2 No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check or one) within 2 29b. Signature and title of certifier 50)02 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 100 anney 32. Registrar's Signature 31. Date filed (Month, Day, Year) State OCT 19 2006

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Registrar

ADEBOWALE

OCT 1 8 2006

31. Date filed (Month, Day, Year)

AJAYI M.D.

32. Registrar's Signature

6201 GREENBELT ROAD # U15 GREENBELT, MARYLAND

			For State Registrar	.,	State	of Man	-	epartmen Certificat		Health and I		jiene ()	06	34756
			1. Decedent's Nam	e (First, Middle	e, Last)						2. Date of Dea	th Day	Year	3. Time of Death
-	Physicia /Medic	100	Pie	rcezend	lo Ashto	n Jack	son				October	13	2006	7:01 P M
	Examin	er	4a. Facility Name (						Town, o	or Location of Deat	h	4c. Cour	nty of Death	
			Wa 5. Social Security N		n Advent		lospital In yrs. last birth			akoma Par			Montg	
	Funeral Director				6. Sex 1∭ M 2□ F		59 Y	Months		Hours Min.	(Month, Day	Year) 194		lace (State or Foreign try)
			578-64- Usual Residence of				39				Sept. 20	J, 194	/ was	h., DC
	yłanc how	. [	10a. State	10b. County		10	0c. City, Town	or Location					11	Od. Inside City Limits
	e Ma	cto	DC							Washing				1 DXYes 2 No
	ों or 28	Director	10e. Street and Nu					10f. Zip		10-16-6		10g. Citizen o	of What Coun	try?
	er death with the Marylar terns 23a or 28a-f ehow minimal be codiffied at			01 Jay	St., NE			40 W D		0019-372.			ited S	
	Items Items	Funerai	<ol> <li>Marital Status</li> <li>Never Mari</li> </ol>	ried 2□ Marı	Armed	Decedent Eve d Forces? es 2 □ No	er in U.S.	Il Yes, spe	cify Cub	Hispanic Origin? (S an, Mexican, Puer	to Rican, etc.)	B	lack, White,	
336	urs aft	by F	3 Widowed	_	If Yes, Year o	es 2 No , Give or Dates:		1 🗆 Yes	2 <b>X</b> No	Specify:		Spec	city: B1	ack
0-0	filed within 72 hours after death with the Maryland Hygiene Ather than "natural, or ttems 23a or 28a-f ehow ent, Ira Medical Exart ar mual or cotified at	Completed	/500	15. Deceden	it's Education st grade complete	nd)	16a. C	ecedent's Usu	al Occup	pation during most of wo	rking	16b. Kind ol	Business/Ind	dustry
218	thin 7	npie	Elementary/Sec		T -	ge (1-4or 5+)	· '	ife. DO NOT u	se retire	d)	nang			
2	ygien ygien her th		12t		(			Contra	ct S	ecurity (		Administra Comm	Priva	te
pug	be fill he de de de de de de de de de de de de de	Be	17. Father's Name			al-a	Can			18. Mother's Nai	me (First, Middle,	maioen sum th Ash		
Maryland 21215-0036	should be nd Mental marked c	٦ و	19a, Informant's N		ng L. Ja	CKSUII,		Mailing Address	s (Street	and Number or Ri				Code)
Ma	and 2 sealth and 2 sealth and 27 is ner trau				cson, Jr	/Brot		4300 Ja			Wash., Do			
ō.			20a. Method of Dis	sposition			20b. Place of D		me of		Date Date		n - City or To	wn, Slate
Baltimore,	Pages nent of h int: if its			☐ Cremation 5 ☐ Other (S	3 □Removal fri Specify)		·	•		Cem. 10	/26/2006	Tr	fancle	VA
alti	partition porta		21. Signature of F	neral Service	License	1	<u> </u>				tewart Fi			,
ω	Depa impo eny ii		9	hn	Slew	rail	III		4001	Benning				20019
	* * *		23a. Part1. Enter shock, by hea	the disease, or art lailure. List	complications th	nat caused the	Do no	t enter the mo	of dy	, such as cardia	c or respiratory ar	rest, 1		Approximate Interval Between
	Physician		Immediate Chise disease or conditi	on			all	1101	111	monal	4 1111	11		Onset and Death
	/Medical Examiner		resulting in death)		Due	to (or as a c	consequence of	F-1	0000		1			
	T. 76	-	Sequentially list confirmany, leading to incause. Enter Und	onditions,	b	to (or as a c	consequence of	nuc	'ac	umice				
	nsi lited	Examiner	Cause (Disease of	r injury	<	(		1						
w	be executed	Exar	that initiated event resulting in death)	ts Last	c. Due	to (or as a c	consequence of	):						
7 760	ate be execute	cai			L d									
68	tificat ng phy as th		15.55.44.5	<del></del>	1							l		
Box	death certifica e attending ph id for use as th	an/h	IF FEMALE: 23b. Was deceded			outcome of ve birth 2 [	pregnancy Fetal death	3 □Ectopic p	regnanc	y			Date of delive	
¥	e dea the att	sici	in the past 12 1 Tes 2 9 Unknow	□No	4□Pr	regnant at tim nknown		5 Dther (s		•			Month	Day Year
P.0	requires that the death certifica een signed by the attending ph nould be detached for use as th	by Physician/Med	Part II. Other sign		ons contribution	to death but o	not reculting in	he underlying	Called Ch	von in Part I	23e Did to	haceo use co	ontribute to th	ne cause of death?
ds,			Tan III. Other Sign	)0m	onti	0-		ine underlying t	Jause gr	voir in a citt.			3 Prob	
Lum Record	> 0 %	ete		1010	19/2 pl	1 0000					24a. Was	an #24	h Wara auto	psy findings available
Re	8 8 6	Completed		M	ar www.	////					autop perfor	med3	prior to cor death?	npletion of cause of
ta	ician: Th certificate ector, pag	မ C	25. Was case rele	erred to medica						26 Place of De	1 ☐ Yes ath (Check only o		1 🗌 Yes	21160
Vita	ysicia s cert direct	To B	examiner?	1	Hospital	Inpatient	2 ER/Outp	atient 3 Do	OA Ott	har	dome 5 Resid		Other (Specifi	<i>(</i> )
Jof	Attending Physician: The Ir death. sctor: After this certificate haby the funeral director, page		27. Manner of Dea		28a. D	ale of Injury Month, Day Y			28c. Inju Wo		28d. Describe h			-
<u></u>	endin sath. or: Af he fur	atic	1 ☑fNatural 2 ☐ Accident	5 Pendir investi	gation			м		Yes 2 □ No				
Division	r Att ter de irect n by t	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 □ Could determ	nined 286. P	lace of Injury uilding, etc. (	r - At home, farr (Specify)	n, street, factor	y, office		281. Location (S City or Tow	itreet and Nu. m, State)	mber or Rura	I Route Number,
۵	urs al		On Codifies	150 Continu	as Physician T	Ab = b = A = 6		4						
	To the Hospital or Attent within 24 hours after deatl To the Funeral Director: completely filled in by the	edical	29a. Certifier (Check only one)		Examiner: On th		xamination and			ime, date and place opinion, death occ				
	To the within To the complex	Me	29b. Signature an	d title of dertifie	or			29	c. Licen:	se number	11	29d. Date sig	ned (Month,	Day, Year)
				1	1	_				501	41	10	16/01	5
0.4	2/4/		30. Name and add	iress of person	who completed	cause of deal	th (Item 23a) (T	ype, Print)				14	1	
<u> </u>	U			SREEN	KANG	60.	7610	CARR	011	AUE.	IAKon	n Far	Am)	20912
	Sta Registr		31. Date filed (Mo	nth, Day, Year,	nos K	2. Registrar's	s Signature	noch		AUE.		,		
	33. 4		40	,			- /	1000						

			For State	State of Maryla				Mental Hy	giene 00	6 34757
			Registrar	-41	Ce	rtificate of L	Jeath		Reg. No.	0 0 1 7 0 7
ı	Physici		Decedent's Name (First, Middle, La George Henry J					2. Date of De Month	Day, Y	3. Time of Death
	/Medio Examir		4a. Facility Name (If not institution, giv	e street and number)		4b. City, Town, or	Location of Deat		4c. County of	
		<u> </u>	Memorial	HOSP.	ITAL	EAS	TON		TA	lbot
	Funeral Director		5. Social Security Number 6. S 578–38–7739	ex 7. Age (In y	rs. last birthday) Yrs.	Months Days	If Under 24 Hrs Hours Min.		rth 9 ay, Year)	Birthplace (State or Foreign Country)
			Usual Residence of Decedent					3/30/	29 F.	Md.
	ylan		10a. State 10b. County	10c.	City, Town or Lo	cation				10d. Inside City Limits
	Ba-f	ctor	Md. Caroli	ne	Pre	ston				1 No 2 No
	death with the Maryland ims 23a or 28a-f ehow ir must be notified at	Funeral Director	10e. Street and Number 23564 Jonestow	n Lane		10f. Zip Code	21655		10g. Citizen of Who	·
	eath	era	11. Marital Status	12. Was Decedent Ever in	118 13	Was Decedent of Hi		Specific Voc or No		American Indian,
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heelih and Mental Hygiene. Importment of Heelih and Mental Hygiene. Instruction of Heelih and Mental Hygiene.  In important: if item 27 is marked other than "natural; or items 23a or 28a-f show any injury or other traumatic event, the Macical Examinat must be notified at ances.	by Fun	1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	Armed Forces?	152	Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2☑ No	Specify:	to Rican, etc.)	Black, Specify:	White, etc. Black
Ŏ	2 hor	ted	15. Decedent's Ed		16a. Dece	dent's Usual Occupa	ation		16b. Kind of Busin	ness/Industry
215	thin 7	gl	(Specify only highest gra	College (1-4or 5+)	life.	kind of work done of DO NOT use retired,	luring most of wo	rking		
2	ygien t, the	Completed by	6th		Cu	stodian			Private	Industry
Maryland	be fill htal H bd off	Be	17. Father's Name (First, Middle, Last, James E. Johns						, Maiden Sumame) ry Butler	
Ž	houid d Mei mark	2	19a. Informant's Name/Relationship (		10h Maili	a Address (Street a			er, City or Town, Sta	
Ma	od 2 s lith an 27 ie : traul		Theresa A. Johnson							n, Md. 20784
ē,	t Hee		20a. Method of Disposition		p. Place of Dispo		-	Date	20c. Location - Cit	
Baltimore,	Page lent o nt: if ry or		1 Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specification 5 ☐ Other (Specification 5)			ection Cen	, 1	20/06	Clinton.	Maryland
alti	permit. Departmimporta		21. Signature of Funeral Service Licer			Name and Addres H.S.Was				rarytara
8	89 5 8		Jany 1	W. YLATE	- 4	925 Burro	oughs Ave	a sons ≥.,N.E.,	washingto	n,D.C.20019
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the do	eath. Do not ent	er the mode of dying	g, such as cardia	c or respiratory a	rrest,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	LUNG	CAN	CER				Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a cons	sequence of):					
	_xammer	ē	Sequentially list conditions,	b. Zea to (or as a core	tentuar con offe					
	uted d ansit	mine	Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events	20010 100 2000	0400000					
o,	icate be executed physicien and s the burial-transit	Examin	resulting in death) Last	Due to (or as a cons	sequence of):					
8760,	ate be nysicie he bu	dical		d						
	artifica ing ph e as th	au r	IF FEMALE:							
Вох	ath ce	ian/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of prediction 1 ☐ Live birth 2 ☐ F	etal death 3 [	Ectopic pregnancy			23d. Date o	
P.O.	that the death certific ed by the ettending p detached for use as	Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant at time of 9 ☐ Unknown	ofdeath 5□	Other (specify)			World	ouy roa
<b>a</b> .	that ined by deta		Part II. Other significant conditions of	ontributing to death but not	resulting in the u	nderlying cause give	n in Part I.	23e. Did t	obacco use contribu	ite to the cause of death?
of Vital Records,	The law requires that the death certifi tie hes been signed by the ettending bage 2 should be detached for use as	ed by						10	Yes 2□No 3[	Probably 4 □Unknown
000	e law requ hes been je 2 should	Completed						24a. Was		e autopsy findings available
Œ.		E O						autor perfo	rmed2 dea	r to completion of cause of th? Yes 2 No
/ita	ysiclan: is certific director,	Be (	25. Was case referred to medical examiner?				26. Place of Dea	ath (Check only o		
<u>&gt;</u>	<u>~ ∞</u> ~	ို	1 ☐ Yes 2 No		☐ ER/Outpatien	t 3 DOA Othe	4 Nursing F	lome 5 ☐ Resi	dence 6 Other (	(Specify)
ň	Jing P	on:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year,	28b. Time of Injury	Work		28d. Describe	how injury occurred	
isic	Attending r death. ector; After by the fune	cat	2 Accident investigation 3 Suicide 6 Could not be		1		'es 2 □No	201		
á	i or A after Direction by	Certification:	4 Homicide determined	28e. Place of Injury - A building, etc. (Spe	t nome, farm, str ecify)	eet, factory, office		City or To	Street and Number o wn, State)	or Rurai Route Number,
	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: Alter th completely filled in by the funeral	Medical C	29a. Certifier 1 Certifying Ph	ysician: To the best of my kiner: On the basis of exam and manner stated.	knowledge, death ination and/or in	n occurred at the tim vestigation, in my op	e, date and place inion, death occu	e, and due to the arred at the time,	cause(s) and manne date and place, and	er as stated. due to the cause(s)
	To the within To the Comple	Me	29b. Signature and title of certifier			29c. License	number		29d. Date signed (A	Month, Day, Year)
			> folials	their		D00:	59487	7	10/14	106
0	(4)		30. Name and address of person who	completed cause of death (I	tem 23a) (Type,	Print)				,- <b>E</b>
	0		John Botsis m	D 2165Wash	ington ?	St. ELSTA	n, MD o	11601		
	Sta Registr		31. Date filed (Month, Day, Year) OCT 1 9 2006	32. Registrar's Sig	nature	2				

State of Maryland / Department of Health and Mental Hygien 34758 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 12 2006 **Physician** OCTOBER ISABELLE JOHNSON 1:25 A M /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death THE MILLENNIUM OF FORESTVILLE FORESTVILLE PRINCE GEORGE'S 5 Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, MAY 26 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days 1 □ M 2√2 F 187-22-3315 96 Director 1910 VIRGINIA Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene.
int: If item 27 ie marked other than "natural", or Iteme 23a or 28a-f ehow 10c. City, Town or Location 10a State ir than "natural", or Itame 23a or 28a-f ehow the Medical Examiner must be notified at 10d. Inside City Limits Director 1 ☐ Yes 2 ☐ No PRINCE GEORGE'S CAPITOL HEIGHTS 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 907 SITKA LANE 20743 U.S.A. Be Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ②No If Yes, Give Year or Dates: 11. Marital Slatus Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No BLACK Specify 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) UNKNOWN HOUSE KEEPER PRIVATE other treumatic avant, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) UNKNOWN UNKNOWN ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MELVINA JOHNSON/DAUGHTER 907 SITKA LANE CAPITOL HEIGHTS, MARYLAND 20743 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State ŏ 1 ☐ Burial 2 ACremation 3 ☐ Removal from State Department of Important: If any injury or once. RIVERDALE, MARYLAND 10/13/2006 RIVERDALE, MARYLAND 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 21. Signature of Funeral Service Licensee 7474 LANDOVER ROAD LANDOVER, MARYLAND 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ADVANCED DEMENTIA **Physician** /Medical Due to (or as a consequence of): Examiner HYPERTENSION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (o. as a consequence of): To the Hospitel or Attending Physician: The law requires that the death certificate be executed within 24 hours atter death.
within 24 hours after death.
To the Funeral Director: After this certificate hes been signed by the attending physician and completely filled in by the tuneral director, page 2 should be detached for use as the buriat-transit Due to (or as a consequence of) P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4☐Pregnant at lime of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 ☑ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1 Yes 2 X No 25. Was case referred to medical examiner? Be 26. Place of Death Check only one Hospital: Other: 1 ☐ Yes 2 🗓 No ٩ 1 🗌 Inpatient 2 ER/OutpatienI 4©Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 3 DOA Certification: 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural М 1 Tes 2 □No 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, streel, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 00095314 SPORCON CUO 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SYLVESTER OKONKWO M.D. 6192 OXON HILL ROAD # 507 OXON HILL, MARYLAND 20745 31. Date filed (Month, Day, Year) 32. Registrar's Signat<del>ure</del> State Registrar OCT 1 8 2006

State of Maryland / Department of Health and Mental Hygienes Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death October 304 **Physician** ,2006 BESSIE 12 JONES-TAYLOR /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner DOCTOR'S HOSPITAL LANHAM PRINCE GEORGE'S 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 □ TE Yrs. Director 124-48-8892 AUGUST 30 1917 GEORGIA Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show r than "natural", or items 23a or 28a-f eho The Medical Examiner ritest be notified at MD PRINCE GEORGE'S 1X Yes 2 No Funeral Director LANDOVER HILLS 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6700 REDFIELD AVENUE 20784 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married BLACK þ Specify: permit. Pages 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: if Item 27 ie marked other than "natural", any njury or other treumatic event, the Medical Expons. 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Coltege (1-4or 5+) 12TH RESTAURANT OWNER PRIVATE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be JOE SMITH SUSIE KING 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LUTHER M. TAYLOR/HUSBAND 6700 REDFIELD AVENUE LANDOVER HILLS. MARYLAND 20784 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 

Burial 2 □ Cremation 3 □ Removal from State RESURRECTION CEMETERY 10/21/2006 CLINTON, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of/Funeral Service Licenses 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** 1 110 cardial /Medical Due to (dr as a consequence of): Examiner Hypertension ساراها اللهذارا Saturatively list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed use as the burial-transit and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, ed by the attending physician detached for use as the buria by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 ☐ Probably 4 ☐Unknown cate has been signification can be categorial categoria 1 ☐ Yes 2 ☐ No Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autopsy performed? Yes 2 No certificate is efter deau... rai Director: After this co... 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ✓ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined filled in by 4 Homicide To the Hospital within 24 hours e To the Funeral Completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0042684 30. Name and address of erson who completed cause of death (Item 23a) (Type, Print) Rd., hankam, al 31. Date filed (Month, Day, Year) State Registrar OCT 1 8 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2006 34760 1 - For State Registrar Certificate of Death Decedent's Name *(First, Middle, Last)* Walter Melvin Jarzynski 2. Date of Death 3. Time of Death M°0 - 18-2006 **Physician** 6:30а м /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Talbot Talbot Hospice House Easton | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 12-29-1910 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country)
Baltimore, **Funeral** Yrs Director Usual Residence of Decedent be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or itams 23a or 28e-f ehow treumatic event, the Medical Examiner must be notified at Talbot 1 XYes 2 ☐ No Md Claiborne Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10372 Bayside Dr. P.O. Box 32 21624 USA 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12)
11 years College (1-4or 5+) Tekna Sales &Servic Air Conditioning 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary Wineski Walter Charles Jarzynski မ (wife) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
(wife) 10372 Bayside Dr. Claiborne, Md. 21624 19a. Informant's Name/Relationship (Type, Print) Harriett H. Jarzynski other 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition Pages ' cometery, crematory or other place)
Moreland Memorial 70 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 10-23,2006 Baltimore, MD. ö permit. Page Department of Importent: If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Park 22. Name and Address of Facility
R. Carroll Hurley Funeral Home, PC
P.O. Box 518, St. Michaels, Md. 21663 21. Signature of Funeral Service Licensee , Canol 23a. Part1. Enter the disease, or complications that cause if the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) da Physician /Medical Due to (or as a consequence of): Examiner nanit Equentially liet sor differs, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physiclan/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 🗋 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signt 1 be a Completed by 1 Yes 2 No 3 Probably 4 Unknown peeu 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 certificate 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Pother (Specify) Hospice 1 ☐ Yes 2 ⊡ No ٩ funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident Director: / 3 🗀 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide after To the Hospital within 24 hours a To the Funeral I completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. cal 29a. Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier H42567 Mussell a , Silvey 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Russell Schilling, DO Md. 21601 555 Cynwood Dr. Easton, 31. Date filed (Month Day, Year) gistrar's Signature State 2000 Registrar

			For State Registrar	State of Ma	aryland / [		rtment of He tificate of L			giene Reg. N. (	106	34761
	Physici	an	1. Decedent's Name (First, Middle, L						2. Date of De Month	ath Day	Year	3. Time of Death
	/Medic	al	A		Bennett	Kin		Landing of Dag	October		2006 unty of Death	1:10 A. M
	Examin	ier	4a. Facility Name (If not institution, g. Wilson Nursing				4b. City, Town, or Gaithers		(n		tgomer	
1000	Funeral			Sex 7. Age	e (In yrs. last bir	rthday)	If Under 1 Year	If Under 24 Hrs			9. Birthi	place (State or Foreign
7/2	Director		327–36–1525	1 □ M 2 <b>½</b> F	94	Yrs.	Months Days	Hours Min	May 6			York
	and		Usual Residence of Decedent  10a. State 10b. County		10c. City, Tow	n or Loc	ation					10d. Inside City Limits
	Maryi -f sho	tor	MD. Montgo	mery			Gaithers	ourg				1XYes 2□No
	or 28a	Director	10e. Street and Number				10f. Zip Code			10g. Citizen	of What Cou	ntry?
	23a c	aiD	301 Russell Av	<i>r</i> enue				20877		Ţ	USA .	
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or Items 28a or 28a-f show important: if item 27 is marked other than "natural", or Items 28a or 28a-f show any injury or other traumatte event, the Medical Examinat mutal be notified at once.	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3√2 Widowed 4 □ Divorced	12. Was Decedent I Armed Forces?  1 Yes 2 N If Yes, Give Year or Dates:		If	/as Decedent of Hi Yes, specify Cubar ☐ Yes 2[文No	spanic Origin? (s n, Mexican, Puer Specify:	Specify Yes or No to Rican, etc.)		Race - Ameri Black, White, ec <i>ify:</i> Whi	, etc.
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lan	Aenfal	To Be		Abel H. B	ennett			Ida	Green			
lary	and N		19a. Informant's Name/Relationship			,	Address (Street a			,		
ر ح	and sealth m 27		Barbara Martin .	- daughter			Madonna :	Lane, Bo	Date, Maj			
altimore,	t. Pages 1 tment of H tant: If ite		20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3  4 ☐ Donation 5 ☐ Other (Spec	ity)	-17-06	Alexa	on-City or T ndria,					
Ba	Departing Departing Important in any in concession		21. Signature of Funeral Service Lic	W MB	all		Name and Addres		Beall Fu Hwy., Bo	neral wie, M	Home arylan	d 20715
, v	Crate be executed  Medical Examiner  the burial-transit	dicai Examiner	23a. Part1. Enter the dise se, or co shock, or heart failure. List onl Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a	a consequence	of):	in the mode of dying	, such as cardia	ic or respiratory a	11631,		Approximate Interval Between Onset and Death
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rds, F	luires than signed		Part II. Other significant conditions  (a) X 1   a L Y	contributing to death be	-	n the un	derlying cause give	n in Part I.		obacco use d Yes 2		the cause of death? \( \) bably 4 \( \subseteq Unknown \)
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الما	2		John K	//// o completed cause of d	M	)	<u>D19</u>	1294	,	Octo.	La 1	4,2006
R <sub>L-4</sub>			30. Name and address of person wh	Completed cause of d	eath (item 23a)	t //	Au 1	agi Hhis	Luis. M	d, 200	79	
	Sta Registi		31. Date filed (Month, Day, Year)  OCT 1 7	2006 32. Fegistra	ar's Signature	Sp	ale		0			

			For State Registrar	State of M	Maryland	-	artmen rtificate					gienę Reg. N&	1116	34762
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	Examir	ier	4a. Fecility Name (If not institution, g Ft. Washington		er)				Location of				County of Deat	
	Funeral			. Sex 7.	Age (In yrs. Ia	st birthday)	If Under	1 Year	If Under	24 Hrs.	8. Date of Birt	h	rince G	hplace (State or Foreign
	Director		579-42-1823 Usual Residence of Decedent	1□M 2₫F	78	Yrs.	Months	Days	Hours	Min.	(Month, Day uly 30	, Year) , 19	28 Fors	yth Cty.N.C.
	Maryland	tor	10a. State 10b. County Maryland Prince	Georges		Town or Lo		on						10d. Inside City Limits tt☐ Yes 2☐No
	or 28,	)irec	10e. Street and Number				10f. Zip					10g. Cit	izen of What Co	ountry?
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980	perrait. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Importents if item 27 is marked other than "neturel", or items 23a or 28e-f show any injury or other treumetic event, the Medical Examinat must be notified at ODGs.	by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Married  3 ☑ Widowed 4 □ Divorced	12. Was Deceder Armed Force 1	s? ∑No		Was Deced If Yes, spec 1 ☐ Yes 2	ify Cuba	spanic Orig n, Mexican Specify:	i, Puerto F	cify Yes or No- Rican, etc.)		14. Race - Ame Black, White Specify: B	
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ary	and N		19a. Informant's Name/Relationship	(Type, Print)		19b. Mailir	ng Address	(Street a	and Numbe	er or Rura	Route Numbe	r, City o	or Town, State, 2	Zip Code)
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0	(6)		30. Name and addess of person wh				΄ Α Τ	lfred	l Bur	ris.	M.D.			
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	/Medic Examin	er	4a. Facility Name (If not institution, give si	treet and number)		4b. City	, Town, or Location			4c.	County of Dea	ath
			WASHINGTON AOV  5. Social Security Number 6. Sex	7. Age (In yrs.			KOMA r 1 Year If Und	der 24 Hrs.	8. Date of Bir	th		othplace (State or Foreign
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	nand ow	ŀ	Usual Residence of Decedent  10a. State 10b. County	10c. Cit	y, Town or Lo	cation						10d. Inside City Limits
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	with th		10e. Street and Number 2622 La 2 <del>396 E1vans R</del>			10f. Z	2078 <sup>p Code</sup>	83-141 <del>020</del>	17	10g. Citi	zen of What C	d States
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	ss 1 and 2 should of Health and Me Item 27 ie mark r other traumati		19a. Informant's Name/Relationship (Type Kevin Lineberger	·		-	ans Rd.,				20020	Zip Code)
Baltimore,	Pages 1 and neut of Height: If Item		20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Re	amough from State	lace of Dispo	natory or	me of are recent	10-2	7 <sup>ate</sup> 2006	20c. Lo Tria	cation - City o	r Town, State A •
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1	(5)		30. Name and address of person who co	mpleted cause of death (Iter	n 23a) (Type,		00 0	11 4	7n 4		D ===1 = 2	m 20010
4	Sta	et e	JARCIE 31. Date filed (Month, Day, Year)	32. Registrar's Signa	afure 🌶 –		00 Carro	OTT AA	re., Tak	oma	rark, N	MD 20912
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			- State	te of Mar	yland / De	partment of I e <i>rtificate of</i>	Health and I Death			006	34764
	*	***	Registrar  1. Decedent's Name (First, Middle, Last)			er timeate or	Death	2. Date of De Month	ath Day	Year	3. Time of Death
	Physici /Medic		William F. Loga					October	12 2	2006	5:03 pm
	Examin	er	la. Facility Name (If not institution, give street a  Doctor's Community He			4b. City, Town, Lanham	or Location of Death	1		ounty of Death ince Ge	orge's
Ų va	Funeral Director		5. Social Security Number 223–36–8669 X M 2	7. Age (/	In yrs. last birthda Yrs.			8. Date of Bir (Month, Da 3–12–1		9. Birthr	place (State or Foreign ntry) fax Co., VA
	and		Usual Residence of Decedent 10a. State 10b. County	10	Oc. City, Town or	Location					10d. Inside City Limits
te	Maryl a-f sho	tor	MD Prince Georg	ė's l	Lanham						X☐Yes 2☐No
etahe	th with the 23a or 28a	Funeral Director	10e. Street and Number 6203 Main street			10f. Zip Code 2070	6			en of What Cou ted Sta	
1 10	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Heath and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examenation must be notified at angle.	by	1 Never Married 3 Married 1 Nover Married 1 No	s Decedent Eve ned Forces? Yes 2 □ No es, Give ar or Dates:		3. Was Decedent of If Yes, specify Cult 1 ☐ Yes 2 ☑ No	oan, Mexican, Puert	pecify Yes or No o Rican, etc.)		Black, White,	etc.
7 F	"natur	Completed	15. Decedent's Education (Specify only highest grade comp	oleted)	(G.	cedent's Usual Occu ve kind of work done o. DO NOT use retire	during most of wor	rking	16b. Kind	d of Business/In	dustry
212	d within	omo	Elementary/Secondary (0-12) Co	llege (1-4or 5+)		sportatio		ist	Head	quarter	sMarine Co.
	id be file lental Hyg ked othe ic event,	To Be C	17. Father's Name <i>(First, Middle, Last)</i> James Logan				18. Mother's Nar Carri	ne (First, Middle Le H <b>il</b> l	, Maiden Si	umame)	
$\mathcal{A}_{ary}$	nd 2 shoualth and N 27 is mai		19a. Informant's Name/Relationship (Type, Pri Henrietta S. Logan	nt) ( Wife		alling Address (Stree 3 Main st					o Code)
an / imore,	ges 1 a t of Hea if item or othe		20a. Method of Disposition  1 Burial 2 Cremation 3 Remova			position (Name of rematory or other pla		Date		ation - City or To	
Dadn Bartimore	it. Paritmen rtant: injury		4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service Licensee		Fort Lir	coln Ceme	etery 10/ ess of FacilityFor	18/2006 t Linco		ntwood, neral H	
3,8	Per Imp		Luhar Thorn				lensburg				
1			23a Part1. Enter the disease, or complications shock, or heart failure. List only one cause	s that caused th se on each line.	e death. Do not	enter the mode of dy	ing, such as cardiad	or respiratory a	rrest,		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a c	consequence of):	ORESPU	PATDRY	FKI	INVE	-	1 Day
	Examiner			those	TENSUE ]	prin	161280N	ope '	April	T 1180	BE YV
	ned Insit	Examiner	Seguentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	Oue to (or as a constant) $Q \mapsto Q$	consequence of):						100
oʻ	icate be executed physicien and s the burial-transit		resulting in death) Last	Due to (or as a c	consequence of):						, vary
8760,	cate be physici the bu	dical	d								
P.O. Box 6	w requires that the death certific been signed by the attending F should be detached for use as	Physician/Me	in the past 12 months?	res, outcome of Live birth 2   Pregnant at tin	Fetal death	3 □Ectopic pregnan 5 □ Other (specify)	су		23	ld. Date of deliv Month	ery Day Year
	s that t ned by e detac	by Ph	Part II. Other significant conditions contributi	ng to death but i	not resulting in th	e underlying cause g	iven in Part I.	23e. Did	tobacco use		he cause of death?
ords	require sen sig nould b		WO124000	ABB	K1 1280	4,8	)/8EKLE	10	Yes 2		bably 4. Dunknown
Division of Vital Records,	as b	Completed								prior to co death?	opsy findings available ompletion of cause of
Vita	Physician: this certific at director,	Be	25. Was case referred to medical examiner?	1: _ /		10	the are	ath Check only			
ō	Jing Phys n. After this funeral di	n: To	27. Manner of Death 28a	1 Date of Injury (Month, Day Y	28b. Tim	e of 28c. Inj	4 🗀 Nursing r	dome 5 ☐ Resi 28d. Describe			<u>(v)</u>
sion	Attending or death.	catlo	1 DMatural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be			M 1[	Yes 2 □No				
Divi	after d Direct	Certification:	3 Suicide 6 Could not be determined 286	<ul> <li>Place of Injury building, etc.</li> </ul>	<ul> <li>At home, farm, (Specify)</li> </ul>	street, factory, office	9	28f. Location ( City or To		Number or Rur	al Route Number,
	To the Hospital or Attending Physician: The I within 24 hours after death.  To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Medical C	29a. Certifier (Check only one) 1 Certifying Physician (Check only one) 2 Medical Examiner: O ar		xamination and/o						
	To the within To the Comp	Me	29b. Signature and title of certifier		1 20000000000	29c. Licei	nse number		29d. Date	signed (Month,	Day, Year)
0.0	(a)	,	30. Name and address of person who complete	ed cause of dos	th (Item 22a) (To	4 DIVOC	00016	197	<i>\</i>	0,19-	06
OK	- We	1	ANOVES C. UN	PA, M	0 - 433		-seven	, par.	Mai	W. Marie	ord and
	St. Regist	ate	31. Date filed (Month, Day, Year)  OCT 1 7 2006	Registrar's	s Signature				12.00	-	2/
8 8	ricgist		001 - 1 2000		A 160						

State of Maryland / Department of Health and Mental Hygiene 34765 Certificate of Death 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) **Physician** OCTOBER 14, 2006 CORNELIA H. LEWIS 2110 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner TALBOT HOSPICE HOUSE TALBOT If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 12/27/1921 Birthplace (State or Foreign Country) 6 Sex 7. Age (In vrs. last birthday) **Funeral** Days Hours 1 ☐ M 2 😿 F 216-12-1974 84 Yrs. MD Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show 1 TYPes 2 □ No Director EASTON TALBOT 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21601 640 MECKLENBERG AVE., APT. 229 72 hours after death Funerai 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 2 Your of Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ▼ No Specify: à Specify: 3X Widowed 4 ☐ Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry e filed within al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) SPECIAL EDUCATION TEACHER 0 12 traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be fill timent of Health and Mental H tant: If itam 27 is marked ott jury or other traumatic even SARAH MCQUAY CARDIFF R. HALL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9052 NEW ROAD, WITTMAN, MD 21676 BRENDA J. LINDSAY/DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State permit. Page Department o Important: If any injury or once. 10/20/2006 HURLOCK, MARYLAND \* 4 ☐ Donation 5 ☐ Other (Specify) MD VETERANS CEMETERY 21. Signature of Funeral Service Licensee 22. Name and Address of Facili FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA JOHN R. MERCEROI 200 S. HARRISON ST EASTON, MD 21601 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequ Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. attending physician Physician/Medical JE FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy jo in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) ed by the a detached f 9 Unknown is been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 □ No 3 Probably 4 Unknown certificate has been 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 2 No Taylure 1 Tes director Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 1 ☐ Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3□ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 X ther (Specify) HOSPICE funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After or Attending 1. Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation death. 2 Accident completely filled in by the Diractor: 6 Could not be 3 T Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 THomicide within 24 hours a To the Funaral I 1XCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 46820 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JENNIFER HOLLYWOOD M.D.538 CYNWOOD DR. EASTON, MD 21601 2. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar OCT 1 8 2006

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** OCTOBE JANE SMITH LEWIS 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner EASTON TALBOT EASTON MEMORIAL If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) 5. Social Security Number **Funeral** 1 ☐ M 2 📉 F Director 186-16-9808 84 MAR 15, 1922 PA Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits \*ohe item 27 is marked other than "natural", or iteme 23a or 28a-f shov other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Director MD TALBOT EASTON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7870 DOVER NECK ROAD 21601 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: WHITE Completed by 3X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be liled within 72 Department of Health and Mental Hygiene. Importent: if Item 27 is marked other than "nn any injury or other traumatic event, the Medit obce. Elementary/Secondary (0-12) College (1-4or 5+) 12 OWN HOME HOMEMAKER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ၉ LAWRENCE SMITH MILDRED WHITE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7870 DOVER NECK ROAD, EASTON, MD 21601 SALLY PETZE/DAUGHTER more, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) DELAWARE VETERANS CEM 10-19-2006 BEAR, DE FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 200 S. HARRISON ST., EASTON, MD 21601

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Onset and Death Immediate Cause (Final disease or condition resulting in death) CEREBROVASCULAR ACCIDENT **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed physicien and the burial-transit Due to (or as a consequence of): P.O. Box 68760, Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy ğ Month Day 4 Pregnant at time of death 5 Other (specify) detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 3 Probably 4 Unknown cete hes been sig , page 2 should b 1 □ Yes 2 □ No. 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 1 Yes 2 No 2 No certificete 1 Yes funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification; To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 5 within 24 hours a To the Funeral [ To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0059487 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JOHN BOTSIS M.D. 219 S. WASHINGTON ST., EASTON, MD 21601 31. Date filed (Month, Day, Year) 32 Registrar's Signature State OCT 1 6 2006 Registrar

State of Maryland / Department of Health and Mental Hygierre 0 0 6 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** Amanda Elizabeth Lindsay 1:20 p<sup>M</sup> October 13 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Ctr 4c. County of Death **Examiner** Carroll Lutheran Village Health Care Westminster Carroll 5. Social Security Number If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 6. Sex 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 ☐ M 2 💢 F Months Director 212-10-9479 Usual Residence of Decedent hours after death with the Maryland 10a, State 10b. County 10c. City, Town or Location 7 is marked other than "natural", or items 23a or 28a-f show treumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director 1 Yes 2 No MD Carroll Westminster 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 300 St. Luke Circle 21158 USA Funerai 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. ☐Yes 2X No Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: White Completed by Specify: 3X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry nd Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home anould be filt.

Alth and Mental Hye.

7 is mark. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be James E. Lloyd Mary E. Akehurst Pages 1 and 2 should I nent of Health and Meni 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2. Department of Health a Importent: If item 27 is any injury or other tret once. 3800 Littlestown Pike Wostminster, ND 21158 to Disposition (Name of tery, crematory or other place) 10/20/2006 20c. Location - City or Town, State James E. Lloyd, Jr/nephew 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State James Church Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Dennings, MD 21. Signature of Funeral Service Licensee Pricts Funeral Home and Chapel, P.A. 412 Washington Road Westminster, MD 21157 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final oronal Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions cause. Enter Underlying Cause (Disease or injury Ь. Examiner Due to for as a considuence of The law requires that the death certificate be executed burial-transit the attending physician and that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical d use as the IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☑ No Month Dav 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. detached 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by 2 should be 1 Yes 2 No 3 Probably 4 Denknown Be Completed been 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has autopsy perform page 1 Yes 2 No certificate 1 □ Yes 2 No Physicien: funeral director, 25. Was case referred to medical 26. Place of Death /Check only one) examiner Other: Hospital: 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To After this 27. Manuer of Death 28a. Date of Injury (Month, Day Ye. r) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred or Attending Natural 5 Pending Injury 1 Tyes 2 🗆 No death. investigation after death Director: / 2 Accident filled in by the 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Snecify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours a To the Funerel L Certifying Physician: To the best of m. knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier cai completely (Check ly one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier Tot D0050763 30. Na Le and address of person who completed cause of death (III m a) (TypenPrint) 10 Mendoza rnesto Poole 000 31. Date filed (Month, Day, Year) 32. Registrar's Signature Sporte 2006 Registrar

_			State of Maryland / Department of Health  1- State Registrer Amend #2.3. Per Phys. R0C10-23-06 cr. Certificate of Deat		ental Hygiem	.000	34768
- 6	Physici	an	1. Decedent's Name (First, Middle, Last)	}	2. Date of Death Month Da	ay 15, Year	3. Time of Death 5:57 P. M
	/Medic	cal	Vera Monia Mariano  4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location		OCTOBER <del>1</del>	2006 c. County of Death	5:51am
	Examin	ier	CIVISTA MEDICAL CENTER LA PLATA	On or Death			
	Funeral	-	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under	der 24 Hrs.	8. Date of Birth (Month, Day, Year	CHARLES  9. Births	place (State or Foreign
	Director		578-70-5818 60 Yrs.		ar. 9, 19		ana
	land ow		Usual Residence of Decedent           10a. State         10b. County         10c. City, Town or Location			1	0d. Inside City Limits
	death with the Maryland ima 23a or 28a-f ahow rittua Ler rivillad at	tor	Maryland Prince George's Camp Spr	rinoe			1X Yes 2 No
	or 28	Director	10e. Street and Number 10f. Zip Code		10g. C	itizen of What Cour	ntry?
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	ter de	Funeral	11. Marital Status  12. Was Decedent Ever in U.S. Ammed Forces?  1 □ Never Married 2 □ Married 1 □ Yes 2 1 No 1 □	Origin? (Specican, Puerto R	ify Yes or No- ican, etc.)	14. Race - Americ Black, White,	
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42	filed Hygid Other	Be Co	THE SE	other's Name (	First, Middle, Maide	Self-Emp	Loyed
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lary	2 should be filed and Mental Hygis Is marked other aumatic avent, II		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Num	mber or Rural	Route Number, City	or Town, State, Zip	Code)
VekA $MA$	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Menial Hygiene. Important: if item 27 is marked other than "natural", or itema 23s or 28a-f show any Injury or other traumatic event, if a Medical Exact are most be recitied at once.		Brian L. Mariano/Son 5103 Silver Va 20a. Method of Disposition (Name of	11ey Da	Way, Camp	Springs,	MD 20746
4	nt of h		1 Burial 2 K Cremation 3 D Removal from State			ocation - City or To	
Hit Se	artme ortani Injury		4 Donation 5 Other (Specify)  Lee's Crematory  21. Signature of Funeral Service Licensee 22. Name and Address of Fac	10/24	/2006 tewart Fun	Clinton,	
B	Depa Impo eny l		Lehm T Stephen 4001 Benn				
5			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such shock, of heart failure. List only one cause on each line.	as cardiac or	respiratory arrest,		Approximate Interval Between
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	/Medical Examiner		Pue to (or as a consequence of):				3
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	cate be executed physician and the burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events  c. Hypkirthings VECORDION	BROW	CAN DE	scase	xneud.
,0	ate be execute hysician and ihe burial-trans		resulting in death) Last Due to (or as a consequence of):				3
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9 X	es that the death certific igned by the attending p be detached for use as	Physician/Me	IF FEMALE: 23c. If yes, outcome of pregnancy			22d Date of delive	
Вох	death e atter d for u	Iclar	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 0			23d. Date of delive Month	Day Year
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s,	Attanding Physician: The law requires that the death certific r death. r death. ector: Atter this certificate has been signed by the attending p by the funeral director, page 2 should be detached for use as by the funeral director.	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Par	irt I.		use contribute to th	
oro	w requir been s should	Completed			1 Yes 2		
Rec	he law s has ge 2 s	ldu			24a. Was an autopsy performed?	24b. Were autor prior to con death?	osy findings available inpletion of cause of
ta	an: Ti		25. Was case referred to medical 26. Pla	D /	1□ Yes 2MN		2 No
<u> </u>	ysician: The lav is certificate has director, page 2	То Ве	examiner? Hospital: A Other		Check only one)  5 Residence	6 □Other (Specify	•)
o =	ding Ph After th funeral		27. Manner of Death 1 Natural 5 ☐ Pending 28a. Date of Injury (Month, Day Year) 28b. Time of Injury at Work? 28c. Injury at Work?		d. Describe how inju		/
sio	Mtandi death. ctor: A y the fu	catl	2 Accident investigation M 1 Yes 2	□No			
Division of Vital Records, P.O.	To the Hospital or Attanding Ph within 24 hours after death. To the Funaral Director: After th completely filled in by the funeral	Certification:	Suicide  4 ☐ Homicide	28	f. Location (Street ar City or Town, State	nd Number or Rurai 9)	Route Number,
	Hospital or 14 hours afte Funaral Dir tely filled in I		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date	and place, an	d due to the cause(s	) and manner as sta	ated.
	he Ho in 24 I he Fu pletely	Medical	(Check only one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, di and manner stated.	death occurred	at the time, date an	d place, and due to	the cause(s)
	To the within 2 To the comple	Σ	29b. Signature and title of certifier	er /	29d. Da	te signed (Month, L	Day, Year)
	(2)		* Jung 1 Show ( ) 1) 20	296	4 11	01161	06,
CIC	- (L)		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	DIRT	. M.l.	2060	3
	Sta		31. Date filed (Month, Day, Year) 2. Registrar's Signature	4 4	, –		
	Registr	ar	OCT 1 9 2006 Kenter & Anne				

State of Maryland / Department of Health and Mental Hygiene 006 34769 For Stata Ragistrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 10:45 Lewis Pohatan Montague October 14, 2006 /Medical 4a. Facility Name (If not institution, give street and number) Potomac Valley Nursing Home 1235 Potomac Valley Road 4b. City. Town, or Location of Death 4c. County of Death Examiner Rockville Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Month, Day, Year
Min. (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1**፭**M 2□F 230-14-3975 4, 92 Yrs. Oct. 1914 Virginia Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County if Item 27 is marked other than "natural", or Itema 23a or 28a-f show or other traumatic event, Ite Madical Examiner mast be notified at 1 X Yes 2 ☐ No DC Directo Washington 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 550 N St. SW 20024 USA Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1935 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ⊠Yes 2 □ No 1 939 & If Yes, Give Year or Dates: '42-'45 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White 3 ☐ Widowed 4 🏝 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Self Employed 11 Builder/Developer 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be UNKNOWN UNKNOWN ဂ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Paulette Powell - Friend P.O. Box 70759 Washington, DC 20024-0759 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 A Burial 2 ☐ Cremation 3 ☐ Removal from State Pohick Cemetery 10/18/2006 Lorton, Virginia 5 Other (Specify) 22. Name and Address of Facility Everly-Wheatley Funeral Home 1500 W. Braddock Rd. Alexandria, Virginia 22302 21. Signature of Funeral Service Licenson 1136 deel 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a conseque Examiner Dementia 1(80 RUNS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner the attending physicien and hed for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? Month Day 4□Pregnant at time of death 5 Other (specify) detached s been signed by t 2 should be detach 23e. Did tobacco use contribute to the cause of death? Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 3 Probably 4 Unknown 1 Tes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 To the negree.

within 24 hours after death.

To the Funeral Director: After this certificate to the Funeral Director, After this certificate to the funeral director, pag 32 No 1 Yes Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA Medical Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27 Manner of Death or Attending 1 Matural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 3 🗌 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signalure and title of certifier 29c. License number Research BUN mile 370 Ro Mendhiralta 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 1 8 2006 Registrar

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		1 - For State Registrar	State of Ma	aryland / Do	epartment Certificate	t of He	ealth ar Death	nd Me		iene	2006	34	770
		1. Decedent's Name (First, Middle, La	st)					2.	Date of Deat	th Day	Yeer		of Death
Physic /Med		Britt Arthur	Martin					0	ctober		, 2006	3:50	рМ
Exam		4a. Fecility Name (If not institution, giv Manor Care Health				Town, or ${f Tows}$	Location of (	Death		4c.	County of Dealti		
Funera Directo		5. Social Security Number 6. S 222-34-7869	Sex 7. Ag	e (In yrs. last birth 56	Months	1 Year Days	If Under 24 Hours	Min.	Date of Birth (Month, Day, Mar 10	Year)	0	rthplace (State Country) Laware	or Foreign
Ð		Usual Residence of Decedent											
anylar show	5	10a. State 10b. County  Maryland Carro	11	10c. City, Town	or Location	T47c	estmin	ctor				10d. Inside	City Limits
the M	Director	10e. Street and Number	<b></b>		10f. Zip		25 CILLI1	racer		On Citi	zen of What C		-
23a or		373 Doral Court			101. 210	Code	2115	8		og. Oiti	USA	Jounity?	
21213-UU36 4 within 72 hours after death with the Maryland piene. r than "natural", or Items 23e or 28e-f show the Marical Examine must be notified at	by Funeral	11. Marital Status  1 ☐ Never Married 2 ☒ Married  3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces? 1 Tyes 2 11 If Yes, Give Year or Dates:		13. Was Deceded If Yes, special Yes 2		spanic Origin n, Mexican, F Specify:	n? (Specify Puerto Ric	y Yes or No- can, etc.)		I4. Race - Am Black, Wh Specify:		
(and Z1Z13-UU36) Id be filed within 72 hours at ental Hygiene. red other than "natural", or c svent, the Medical Exam	ted	15. Decedent's E	ducation	16a. C	ecedent's Usua	I Occupa	tion			16b. Kir	nd of Business	s/Industry	
Third 7	Completed	(Specify only highest gra Elementary/Secondary (0-12)	college (1-4or 5	/	Give kind of won ife. DO NOT us	e retired)		t working			Colleg		
ed wi	Cou	12			Houseke							E	
be fill by out	Be	17. Father's Name (First, Middle, Last Edward Evan Mar							First, Middle, N et Wil]				
hould d Mer marke	၉	19a. Informant's Name/Relationship (		10h A	Mailing Address	(Stroot a						Zin Codol	
9, Maryland Z1Z1; I and 2 should be filed within 7 feath and Mental Hygiene. m Z7 is marked other than 7; her treumatic event. In Men		Edna L. Martin,	• • • • • • • • • • • • • • • • • • • •		73 Dora							21p C006)	
<b>Baltimore,</b> permit. Pages 1 and Department of Healt Importent: If item 2 any injury or other poce.		20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3 ☐  1 ☐ Donation 5 ☐ Other (Special		20b. Place of Connetery,	isposition (Nam crematory or ot arroll (	her place		10/17 200	7		nfield		
Denmit. Departrimports Imports any inj		21. Signature of Funeral-Service Licel	nsee MO	1191	22. Name and			Mye				eral Ho	ome
		23a. Par 1. Enter the disease, or com	plications that caused	the death. Do no							, I'IU Z	Approxima	
Physician /Medica		shøck, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	A .	2 HE11	YER	'Ś	DI	Sea	ese.			Onset and	
Examine			Due to (or as	a consequence or;									
ed sit	Jiner	Sequentially list conditions, if any, leading to transdiate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as	a consequence of									
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OX <b>D&amp;/DU</b> , certificate be executed inding physician and use as the burial-transit	dicai	•	_ d										
D ∰ E S		IF FEMALE:	23c. If yes, outcome	of pregnancy									-31-3
or the arth	Physician/Me	23b. Was decedent pregnant in the past 12 months?  1  Yes 2  No	1 ☐ Live birth 4 ☐ Pregnant at	2 Fetal death	3 Ectopic pre 5 Other (spe					2	3d. Date of de Month	Day	Year
ر الله الله الله الله الله الله الله الل	hys	9 Unknown	9 Unknown					1					
_ 도 일종	by	Part II. Other significant conditions of	contributing to death bi	ut not resulting in t	ne underlying ca	luse giver	n in Part I.			acco us		o the cause of robably 4	death? Unknown
ecords, law requires t as been signe 2 should be c	etec							-					V
	Completed							-	24a. Was ar autopsy perform 1 Yes 2	y	prior to death?	utopsy findings completion of s 2 \(\sigma\) No	s available cause of
VICAL IN icien: The certificate h ector, page	BeC	25. Was case referred to medical examiner?					26. Place of	Death (C	heck only one	-	, , , , ,	2010	
Of Vital Physician: this certificant of the control	To	1 ☐ Yes 2 No	Hospital: 1 Inpatie	nt 2 ER/Outp	atient 3 DO	A Other	4 Nursi	ng Home	5 🗌 Reside	nce 6	Other (Spe	ecity)	
nding Path.	ation:	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injui (Month, Day	ry 28b. Tin Ye <i>ar)</i> Inju	ne of 28	Bc. Injury Work?	at ° ? es 2 □ No	1	I. Describe ho	w injury	occurred		
DIVISION  To the Hospital or Attending within 24 hours after death.  To the Funerel Director: After completely filled in by the funer	Certification:	3 Suicide 6 Could not b 4 Homicide determined		ury - At home, farm c. (Specify)	, street, factory,	, office		28f.	Location (Str City or Town			ural Route Nu	mber,
e Hospit 24 hours E Funere letely fille	ledical (	29a. Certifier 1 Certifying Ph (Check only 2 Medical Example)	nysician: To the best of miner: On the basis of and manner sta	examination and/	death occurred a prinvestigation.	it the time in my opi	a, date and p nion, death	occurred a	due to the ca at the time, da	use(s) a ite and	and manner a place, and du	s stated. e to the cause	(s)
To th To th comp	Me	29b. Signature and title of certifier	2/1			License		0				th, Day, Year)	
2024		30. Name and address of person who	completed cause of d	eath (Item 23a) /To			0 120				7-15-		
10		AH. GHILA	01,190		(pe, Print)	SLE	RD	7.	ouse	N	112	21	204
S Regis	tate trar	31. Date filed (Month, Day, Year)  OCT 1 6		ar's Signature	1								
DHMH 17 Rev 1		22. 10	2006		Lyone			·					

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** BONNY LEE PANOWITZ 10 2006 16 4:00AM Loo Panowitz /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Carroll Hampstead 5263 Wertz Road If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 3/18/1943 1□M 2X F United Director 217-40-3849 63 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits 28a-f ehov 1 ☐ Yes 2 XNo Directo Carroll Hampstead with the 10g. Citizen of What Country? U.S.A. 10e. Street and Number 10f. Zip Code 5263 Wertz Road 21074 death Funerai Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Pages 1 and 2 should be filed within 72 hours after 1 ∐ Yes 2 X No 1 Never Married 2 Married ŏ 1 Yes 2 No White Baltimore, Maryland 21215-0036 Specify þ 3 ∑Widowed 4 □ Divorced Year or Dates er than "nature, Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Bartender Tavern 10 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be ie marked Harold Knight Helen C. Waddell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 i Sheri Sellers Daughter 5263 Wertz Road, Hampstead, MD 21074 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 20a. Method of Disposition ō = 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Dulaney Valley Mem 10/19/2006 Timonium, MD permit. Page Department of important; if eny injury or once. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Eline Funeral Home, 934 S. Main St., 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine To the Hospitel or Attending Physician: The law requires that the death certificate be executed ettending physicien and for use as the burial-tran Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregn 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 mor Month Year Day 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 2 No page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy certificate 1 ☐ Yes Be ( 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 21XN0 5 Residence 6 Other (Specify) 2 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA this Certification: 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation Natural 1 Natural 1 ☐ Yes 2 ☐ No death. within 24 hours after death To the Funeral Director: completely filled in by the 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai (Check only one) 29b. Signature and 29d. Date signed (Month, Dey, Year) ss of person who completed cause of death (Item 23a) (Type, Print 30. Name an South DU 31 Date filed (Month, Day, Year) State Registrar

Amended Item 1 per Physician & Item 10g per F.D. 10/18/2006 Carroll County, wil

ype or i fine in bia	on machibic min.	Elisaic Ali Oc	phies Mie F	egible.	
State of Maryland /	Department of He	ealth and Ment	al Hygiene	2006	

34772 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month Year Physician Carolyn Dorothy Parsons 10 14 2006 0640 M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Wicomico 381364Cl KENI NSULLI If Under 1 Year If Under 24 Hrs. 8. Date of Birth 1/17/1943 Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 K F Days Hours Maryland 63 Yrs 213-46-0877 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits •how Pages 1 and 2 should be filed within 72 hours after death with the Maryla nent of Heelth and Mental Hygiene.
ant: If Item 27 ie marked other than "natural", or Items 23a or 28a-f ehov ury or other treumatic event, the Medical Examinar must be notified at 1 XYes 2 No Somerset Princess Anne Maryland Direct 10e. Street and Number 10g. Citizen of What Country? 10f. Zin Code 21853 USA 30577 Circle Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Completed by Specify white 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Domestic 18. Mother's Name (First, Middle, Maiden Sumame) 17 Father's Name (First Middle Last) Be Reba Stein Parish Robert Vernon Cousins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 30577 Circle Dr., Princess Anne, MD 21853 Charles L. Parsons/husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State ortant: to 10/17/06 Salisbury, MD 4 ☐ Donation 5 ☐ Other (Specify) Salisbury Crematory permit. nature of Funeral Service Licensee Hoffoway Fineral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 Down H. CFSP Champion 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) RESPIRATORY DISTRESS ADULT SYNDROME **Physician** WEEK /Medical Due to (or as a consequence of): Examiner PNEUMONIA 2 WEEK Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner LYMPHOMA 4 MONTH LAR GE The law requires that the death certificate be executed CELL physicien and s the burial-trans Due to (or as a consequence ol): Division of Vital Records, P.O. Box 68760, Physician/Medical as the attending for use as IF FEMALE: use 23c. Il yes, outcome ol pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the a d be detached for ☐Yes 2 ☐No 9☐ Unknown 9 Unknown Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificete hes tirrector, page 2 s autopsy performed? Yes 20 No 1 ☐ Yes 2 ☐ No 1 Yes To the Hospital or Attending Physician: the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Impatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ 1 Yes 2 No 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 5 Pending investigation 1 Matural 1 ☐ Yes 2 ☐ No death. 2 Accident after death n 24 hours after der he Funeral Directo nletely filled in by tr 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28l. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 THomicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a Certifier Medicai within 24 ho

To the Fund

completely f Medical examiner: Un the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier OCTOBER 14,2006 M. SHIRAZI, M.D. PENIN SULA REGIONAL MEDICAL CENTER. MD 21801. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Sparke Registrar 8 2006

			1 - For State Registrar	State of Maryla		artmen rtificate				ental H	ygiene Reg. No	Z U I	06	34773
			Decedent's Name (First, Middle, La	st)					2	2. Date of D	eath			3. Time of Death
	Physici		Raymond R	losemond						Month Octob	er 14	, 20	)06	7:30 a M
	/Medio Examir		4a. Facility Name (If not institution, giv	re street and number)		4b. City,	Town, or	Location of	of Death		40	. County	of Death	
п			Southern Maryla	nd Hospital		Cli	nton	l			I	rinc	e Ge	orges
	Funeral		5. Social Security Number 6. S	Sex 7. Age (In yrs		If Under Months	1 Year Days	If Under Hours	Min	. Date of 8 (Month, L	av. Year		Cour	lace (State or Foreign
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	pu *		Usual Residence of Decedent  10a. State 10b. County	10c. C	ity, Town or Lo	ocation							1	0d. Inside City Limits
	daryli ho	ច		Georges	Suitlar	nd								P∑Yes 2 No
	28°-1	Director	10e. Street and Number			10f. Zip	Code				10a. Ci	tizen of V	Vhat Cour	ntry?
	with a second	ā		Ant #203			20746						Sta	•
	ne 23	Funerai	4242 Suitland Rd.	12 Was Decedent Ever in I	J.S. 13.	Was Deced			gin? (Speci	fy Yes or N		14. Race	e - Ameno	an Indian,
<b>,</b>	ter d	F	1 Never Married 2 Married	Amed Forces? 6 / 2.  1 Yes 2 No 6 / 2.  If Yes, Give 6 / 23  Year or Dates:	3/58				i, Puerto Ri	ican, etc.)			k, White,	
ဗ္ဗ	e l'.	by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates: 6/23	/60	1 Yes 2	2121 No	Specify:				Specify	Blac	K
21215-0036	within 72 hours after deeth with the Maryland ene. Then "naturel", or iteme 23a or 28e-f ehow he Medical Examinar mant be notified at	Completed	15. Decedent's E (Specify only highest gra		16a. Dece	dent's Usua kind of wor	al Occupa	ition fu <i>rina m</i> os	t of working	,	16b. K	(ind of Bu	ısıness/in	dustry
7	uthin	npie	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT us	se retired)	)						
7	t.	ပို	12		Tran	isport	atio					civat		
밀	itel H d ott	Be	17. Father's Name (First, Middle, Last	_						First, Middl		Sumam	Θ)	
$\frac{8}{5}$	Mer Marke Marke	2	Leonard Rosemond		105 14-33	ng Address	(0)			ne Br		as Taura	Ctata 7ia	Codel
Maryland	d 2 st th and 7 le n treun		19a. Informant's Name/Relationship ( Sylvia Ruffin /	•		2 Suit								746
e,	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Department of Health and Mentel Hydiene.  Department of Health and Mentel Hydiene.  Department of Health and Mentel Hydiene.  Department of Health and Mentel Hydiene.  Department of the recommendation of the Medical Examination of the notified at Once.		20a. Method of Disposition	20b.	Place of Dispo	osition (Nan	ne of		Dai					own, State
2	ages int of t: If I		1 Burial 2 Cremation 3 4 Donation 5 Other (Special	JHemoval from State	cemetery, cre ryland				ct 2	3,200	Che	alter	ham.	Md.
Baltimore,	artme ortan Injuri		21. Signature of Funeral Service Lice											
B	Dep Pen		1 trit 00	Ser MOIC	785	5538 <sup>a</sup>	mder Mari	boro	Pope Pike	Fore:	at H	mes,	Mg: A	20747
			23a. Part 1, Enter the disease or com	plications that caused the dea	ith. Do not en	ter the mod	e of dying	g, such as	cardiac or	respiratory	arrest,			Approximate Interval Between
	Physician		shock, or heart failure. List only Immediate Cause (Final	Δ.										Onset and Death
	/Medical		disease or condition resulting in death)	a. Due to (or as a conse	quence of):									
	Examiner		Contract the first secondary	HTD										
	n =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a conse			,							
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Box 6	ding p	/Me	IF FEMALE:	23c. If yes, outcome of pregr	nancv							23d Dat	e of delive	20/
8	eath c	cian	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 ☐ Fet 4 ☐ Pregnant at time of	al death 3[	☐Ectopic pro☐Other (sp						Mor		Day Year
o.	thet the death certification of the ottending detached for use as	ysi	1 U Yes 2 No 9 Unknown	9□ Unknown										
Division of Vital Records, P.O.	Attending Physicien: The law requires that the death certific ridesth.  ctor: After this certificate has been signed by the ettending petter. After this certificate has been signed by the funeral director, page 2 should be detached for use as	by Physician/Med	Part II. Other significant conditions	contributing to death but not re	sulting in the u	ınderlying ca	ause give	n in Part I		23e. Did	tobacco	use contr	ribute to t	ne cause of death?
rds S	quires n signe uld be	d be						_		1	Yes 2	□No	3 Prob	ably 4 Unknown
ပ္ပ	s been si should	olet								24a. Wa		24b. V	Vere auto	psy findings available impletion of cause of
æ	The it	Completed									opsy formed? 2X No		death?	2 No
<u>ta</u>	rtifice	0	25. Was case referred to medical					26. Place	of Death (	Check only	-			<del></del>
>	nysic nis ce direc	To B	examiner? 1 Yes 2 No	Hospital: 1 Inpatient 2	ER/Outpatie	nt 3 DO	Othe	9r: 4 🗌 Nu	irsing Home	e 5□Res	sidence	6 □Othe	er (Specif	y)
0	ng Pt fter t† neral		27. Manper of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	of 2	8c. Injury Work	at ?	28	d. Describe	how inju	iry occurr	ed	
Sio	endli eeth. or: A the fu	catio	2 ☐ Accident investigatio			М	1 🗆 \	res 2 🗌						
\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	or Att	Certification:	3 Suicide 6 Could not be determined			reet, factory	, office		28	f. Location City or T	(Street allown, State	nd Numbi e)	er or Rura	I Route Number,
	To the Hospital or Attending Physicien: The la within 2 duris after death.  To the Funeral Director: After this certificete hes completely filled in by the funeral director, page 2		200 Contine 10 Continue D	hysician: To the best of my kn	ouledge de :	h nearcast	at the time	a data a-	d place an	d due to th	9.00115-/-	) and	nner oo o	lated
	Pun Fun stely (	edical		miner: On the basis of examin and manner stated.										
	To the within 2 To the complet	Me	29b. Signature and title of certifier)			290	. License	number		,	29d. Da	ate signed	(Month,	Day, Year)
	<i>i</i>		Box	m.D			B	006	480	1	1	0/16	106	
,/)	1211	,	30. Name and address of person who			Print)	-		.0 1	2	07	CI	INITE	Day, Year)
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	Sta Registr		31. Date filed (Month, Day, Year) OCT 1 9 2006	32. Registrar's Sign	ature	160								

			1 – For State Registrar	State of Ma	aryland / Depa <i>Cer</i>	artment of I			ene2 0 0 (	5 34774
	يبار بارد		1. Decedent's Name (First, Middle, Last)	-				2. Date of Death Month		3. Time of Death
	Physici /Medio		Genoveva Mar	quez I	Rodriguez			10 - 1		12:55 a <sup>M</sup>
	Examin		4a. Fecility Name (If not institution, give s			4b. City, Town, o		eath	4c. County of De	eath
			Arcola Nursing H			Silver			Montgor	
	Funeral		5. Social Security Number 6. Sex	7. Ag	e (In yrs. last birthday) 85 Yrs.	If Under 1 Year Months Days		in. (Month. Dav.	Year) 9. E	Birthplace (State or Foreign Country)
	Director		Usual Residence of Decedent					03-26-19	921   E1	Salvador
	yland		10a. State 10b. County		10c. City, Town or Lo	cation				10d. Inside City Limits
	a-f st	tor	Maryland Montgome	ry	Takoma	Park				1X Yes 2 No
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Itam 27 is marked other than "natural; or Itams 23a or 28a-f show any injury or other traumatic event. Its Medical Examiner must be notified at once.	Director	10e. Street and Number 8510 Flower Avenue	#2B		10f. Zip Code 209	1.0	10	g. Citizen of What E1 Sa1v	•
	s 23s	Be Completed by Funeral		12. Was Decedent	Ever in II C 12.1			(Canada Van an Na		merican Indian,
	ther de	Fun	11. Marital Status  1    Never Married 2   Married 1	Armed Forces?	No.			(Specify Yes or No- erto Rican, etc.)	Black, W	
98	urs al	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	1	IXIYes 2□ No	Specify: Sa	alvadoran	Specify: W	hite
Õ	72 ho	ted	15. Decedent's Educ		16a. Deced	lent's Usual Occup	pation	1	6b. Kind of Busine:	ss/Industry
21:	thin 7	nple	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5	5+) (Give	kind of work done OO NOT use retire	during most or v d)	vorking		
2	ed wi	Con	0		Hom	emaker	1		Self-emp	loyed
Maryland 21215-0036	be fill Hall Hall Hall Hall Hall Hall Hall H	Be	17. Father's Name (First, Middle, Last)					lame (First, Middle, M	aiden Sumame)	
ž	d Mer d Mer mark matic	ှ	Eugenio Marque:  19a. Informant's Name/Relationship (Type		10h Mailin	a Address (Street	unknow		City or Tourn State	Tin Code)
<u>8</u>	id 2 s lith an 27 is : traui		Bety Barrientos/day		8510 Takom	Flower A	venue #2	Rural Route Number, 2B 1, 20912	City of Town, State	s, 2ip Code)
ē	Hea Hea tam		20a. Method of Disposition		20b. Place of Dispos cemetery, cren	sition (Name of	rial y Land		0c. Location - City	
<u>ا</u>	Pages ent of nt: If i		1 X Burial 2 ☐ Cremation 3 ☐ Re  `4 ☐ Donation <sub>r</sub> 5 ☐ Other (Specify)	emoval from State	Gate of H			-17-2006 S	Silver Sp	ring, Marylan
Baltimore,	mit. F partm portar r injur	1	21. Signature of Funeral Service License	е Л				H. Bacon I		
ä	S S E S		Manda C.	1000	/ / ) .			N.W. Wash		
14			23a. Part1. Enter the disease, or complic shock, or heart failure. List only on	cations that caused e cause on each lin	the death. Do not ente	er the mode of dyi	ng, such as card	iac or respiratory arres	st,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	ACL	ite my	Cod	10	InFor	Chan	Onset and Death
Æ.	/Medical Examiner		resulting in death)	Due to (or as	a consequence of);		<i>y</i>		-     -	
-	Lxammer		Sequentially list conditions, b.							
	ed sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury	Due to (or as	a consequence of):					
•	and al-trar	xan	that initiated events c. resulting in death) Last	Due to (or as	a consequence of):					
8760,	The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	alE			,					
687	ificate g phy: as the	edical	0.							
Вох	death certifica attending ph d for use as t	Z/M	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome		le			23d. Date of d	lelivery
	deatle atte	Physiclan/M	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at		Ectopic pregnancy Other (specify) _	y 		Month	Day Year
о. О	at the by th	hys	9 Unknown	9∐ Unknown		China and				
	res that the de signed by the a be detached f	by	Part II. Other significant conditions conf	tributing to death b	ut not resulting in the un	iderlying cause giv	ven in Part I.	23e. Did toba	icco use contribute	to the cause of death?
ord	w require been sign	ted	$\mathcal{T}$	no pe				1 🗆 Yes	2 No 3	Probably 4 Unknown
e C	has be	ple						24a. Was an autopsy	24b. Were	autopsy findings available completion of cause of
Vital Records,		Completed						performe	ed? death	
/Ita	sicien: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	a a di a la			1-1-1-1	eath Check on one		1
	Physic this c	L L	TE Yes 20 No	ospital: 1 ☐ Inpatie		3 DOA	ner: 4 Nursing	Home 5 Residen		pecify)
Division of	ding F th. After funera	lon	27. Manner of D. ath  1. Natural 5 Pending 27. Accident investigation	28a. Date of Injui (Month, Da)	y Year) 28b. Time of Injury	28c. Injur Wor	yat* rk? Yes 2 □ No	28d. Describe how	injury occurred	
18	tar ea or the	ficat	3 Suicide 6 Could not be	28e. Place of Inju	ury - At home, farm, stre		163 20110	28f. Location (Stre	et and Number or	Rural Route Number,
2	al or safter	Certification:	4  Homicide	building, etc		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		City or Town,	State)	
	ospita hours unara ly fille	Salc	29a. Certifier 1 Certifying Physi (Check only 2 Medical Exemin	ician: To the best	of my knowledge, death	occurred at the tir	me, date and pla	ce, and due to the cau	ise(s) and manner	as stated.
	To the Hospital or At within 24 hours after d To the Funeral Direct completely filled in by	Aedical	onej	and manner sta	examination and/or invited.					
	To with	Σ	29b. Signature and title of ceptilier	1 . 12	مً ، و	29c. Licens	se number	290	d. Date signed (Mo	nth, Day, Year)
	2		100	y ve	- Jul	1 1	434	TI	10/16	1200
2	0		30. Name and address of person who con	npleted cause of de	eath (Item 23a) (Type, F	n + D	1111	Sonin	o CLA	011
	Sta	te	31. Date filed (Month, Day, Year)	2. Registra	ar's Signat <del>ure</del>	11-4		7 101	7 5/1	red,
7	Registr		OCT 1 7 2006	Blow	A Charl			,		

₹*	2 25		1 - State Registrar Amend#26 Pe		18-06	cr Cer	tificate of	Death		Reg. No.	06	34775
	Physici /Medic		Kodcia	•	Saler	n			2. Date of De Month 10	10 200	Year 6	3. Time of Death 12:00a M
	Examir		4a. Facility Name (If not institution, give				4b. City, Town, o	or Location of Dea	ith	4c. County	of Death	<u> </u>
			11 Helms Pick		(la la		Catons			Balti		
	Funeral Director		5. Social Security Number 6. S 219-49-9692 1  Usual Residence of Decedent	ox 7. Age □ M 2\Q F 5		Yrs.	Months Days	If Under 24 Hr. Hours Min		y, Year)	9. Birthp Coun Alge	ace (State or Foreign try) ria
	yland 10w		10a. State 10b. County		10c. City,	Town or Loc	ation				10	Od. Inside City Limits
	Ba-f et	ctor	Md. Montgom	ery	Silver Spring							1 ☐ Yes 2 XNo
	th with th	ai Director	3600 Glen Eagle	es Dr.			10f. Zip Code 2090	6		U.S.A.	Citizen of What Country?	
036	2 should be filed within 72 hours after death with the Maryland and Mendal Hygiene. and Mendal Hygiene. I alwarked other than "natural; or Items 23s or 28s-f ehow eumatic event, the Medical Examinational be medified at	by Funerai	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces?	1 ☐ Yes 2 X No If Yes, Give 1		/as Decedent of Ł Yes, specify Cub □ Yes 2 1 No		Specify Yes or No rto Rican, etc.)		- Americ k, White, k	etc.
Maryland 21215-0036	within 72 ho ene. then "natur he Medical	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)	de <i>completed)</i> College (1-4or 5-		(Give H life. D		during most of wo d)	orking	16b. Kind of Bus		
and 2	ould be filed Mental Hygis arked other atic event, I	To Be Co	17. Father's Name (First, Middle, Last)  Mohamed Sal	<u>5</u> + .em		Real	Estate		ıme (First, Middle,			ite
ary	should Mand Merican	F	19a. Informant's Name/Relationship (7	ype, Print)		19b. Mailing	Address (Street	and Number or R	ural Route Numbe	er, City or Town, S	State, Zip	Code)
<u>~</u>	end 2 leelth m 27 i			daughter					t,Cator		•	
0 0	ages 1 nt of H t: if ite		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐				ition (Name of atory or other pla Heaven	ce)	Date / 1 2 / 0 6	20c. Location - (	•	wn, State ring, Md.
Baltimore,	permit. Pages 1 end 2 should be Department of Health and Menta Important: If Item 27 is marked eny injury or other treumatic ex page.		4 Donation 5 Other (Specify 21. Signature of Funeral Service Licen			22.	Name and Addre	ss of Facility U	niversa	1 Morti	arv	
			23a. Part1. Enter the disease, or comp	olications that caused t	the death.						on ,	DC 20011 Approximate
	Physician /Medical		shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	one cause on each line	e. LREA	Tic		NCER				Interval Between Onset and Death
	requires that the death certificate be executed X and a signed by the attending physicien end Hould be detached for use es the burial-transit	edicai Examiner	Sequentially list conditions, flary, leading to minipulate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a c. Due to (or as a d.								
вох ев	leath certifica attending ph		200. Was decedent program	23c. If yes, outcome o			Ectopic pregnancy	,	100 H. 17 L	23d. Date		•
о. П	that the dea ned by the at detached fo	Physician/M	in the past 12 menths? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4☐Pregnant at ti 9☐ Unknown			Other (specify)			Mon	th I	Day Year
rds, r	w requires that s been signed b should be deta	Ď	Part II. Other significant conditions co	ontributing to death but	t not result	ing in the und	derlying cause giv	en in Part I.		es 2 TNo		e cause of death?
Hec	The law ete hes t page 2 s	Completed						-	24a. Was autop perfor 1 \( \text{Yes} \)	sy pr med3 de	ior to com	sy findings available pletion of cause of
VItal	Physician: Th this certificeteral director, pag	Be	25. Was case referred to medical examiner?	Hospital:			100		ath Check only or	-		Homo of June
	ding h. After fune	tion: To	27. Manufer of Death 1 12 Natural 5 Pending	1 ☐ Inpatient 28a. Date of Injury (Month, Day	2	R/Outpatient 8b. Time of Injury	28c. Injur Wor	4   Nursing r	28d. Describe h	ence 6 XOther ow injury occurre		Hame of Plug
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funeral or the funeral o	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined	28e. Place of Injur building, etc.	e, farm, stree				n (Street and Number or Rural Route Number, rown, State)			
	ne Hospitai on 24 hours a ne Funerei Dietely filled i	edical	29a. Certifier 1 Certifying Phyone) 2 Medical Exam	rsician: To the best of iner; On the basis of e and manner state	examinatio	edge, death in and/or inve	occurred at the tirestigation, in my o	ne, date and place pinion, death occi	e, and due to the durred at the time, d	cause(s) and man date and place, ar	ner as sta	ted. the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier				29c. Licens			29d. Date signed		
1	0		· Cangare Sa	ver MD			D	16619	(	Detobu	12,	2006
	(5)		30. Name and address of person who call VERGARA - S	ompleted cause of dea	ath (Item 2	3a) (Type, P	rint) CANKLIN	Sour	E DR-	BALTIN	uft,	MD-21236
	Stat Registra		31. Date filed (Month, Day, Year)  OCT 1 8 2006	32. Registrar	's Signatui	had						

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legiple. State of Maryland / Department of Health and Mental Hygienes Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Albert Scharch 12:51 October 12 2006 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death of Medical Cente Baltimore Manyland MIVENSITU Baltimore City If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days 218-40-6416 1**X** M 2 □ F Hours 65 7-15-1941 Neavitt, MD Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits MD Talbot Neavitt 1 ☐ Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6458 Main Street 21652 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian Black, White, etc. 1 □ Yes 2 🔀 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 X Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Construction Co. 12 Years Welder 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Albert Howard Scharch Mildred Johnson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mildred Scharch (mother) 6458 Main St. Neavitt, Md. 21652 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Neavitt Cemetery 10-16-2006 Neavitt, Md. 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee . Carroll Hurley Funeral Home, PC .O. Box 518, St. Michaels, Md. 21663 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sepsis weeks Due to (or as a consequence of): Meninaris 3 neeles Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): 3 weeks Ostcarryelvis Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year 4□Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Spondylitis 2 No 3 Probably 4 Unknown 1 ☐ Yes Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No 24a. Was an autopsy performe 26. Place of Death (Check only one)

**Physician** /Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed

**Physician** 

/Medical

**Examiner** 

**Funeral** 

Director

show

Examiner must be notifled at

or items 23a or 28a-f

permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If tem 27 is marked other than "natural", or ite may injury or other traumatic event, the Medical Examines once.

Baltimore, Maryland 21215-0036

P.O. Box 68760,

Records,

Division or Vital

death.

24 hours after deat

To the Hosp within 24 ho To the Fund completely f

Director

Funeral

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Completed

Be

with the Maryland

death v

Examiner physician and s the burial-tran Physician/Medical attending pl for use as t Completed by Be Certification: To filled in

IF FEMALE: 23b. Was decedent pregnant Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Ankylosino 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier

State Registrar

Medical

(Check only one)

29b. Signature and title of certifier

Amy Stump

31. Date filed (Month, Day, Year)

OCT 16

22 S. aveene Baltimore MD 21201 32. Registrar's Signature

MD

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2006

DHMH 17 Rev 1/2001

29c. License number

51678

29d. Date signed (Month, Day, Year)

COTober 12 2006

		State of Maryland / Department of Health and N	
		1 - State Contificate of Dooth	2000 34///
		Registrar  1. Decedent's Name (First, Middle, Last)	Reg. No.  2. Date of Death  3. Time of Death
Phys		ELSIE L. SAUCA	Month Day Year
,	dical niner	4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death	
		Memorial HOSPITAL EASTON	TALBOI
Funer		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	(Month Day Year) Country)
Directo	or	Usual Residence of Decedent	FEB 21, 1911 KANSAS
/iend		10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits
Man Man	to	MD TALBOT EASTON	1 <del>X</del> Yes 2 □ No
5-0036 2 hours effer deeth with the Maryland atural; or leans 23a or 28a-f show sall Examinat must be notilised at	Director	10e. Street and Number 10f. Zip Code	10g. Citizen of What Country?
oth will	ra l	501 DUTCHMANS LANE 21601	USA
E) gramma	Funeral	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispanic Origin? (Sp. 14. Was Decedent of Hispanic Origin?)	(Specify Yes or No- into Rican, etc.)  14. Race - American Indian, Black, White, etc.
336	by F	1 Never Married 2 Married 1 Yes 2 No If Yes, Give 1 Yes 2 No Specify: 3 Notation 1 Yes 2 No Specify:	Specify: WHITE
-1 . O G G	ted		16b. Kind of Business/Industry
1215- 1215- within 72 ene.	Completed	(Specify only highest grade completed)  (Give kind of work done during most of work life. DO NOT use retired)  (Give kind of work done during most of work life. DO NOT use retired)	orking
		12 2 BUS DRIVER	PUBLIC SCHOOL
laryland 2 2 should be filed and Mental Hygic is marked other eumatic svant, I	Be		ame (First, Middle, Maiden Sumame)
laryla and Men is marke	မို		IE KRACKE  Rural Route Number, City or Town, State, Zip Code)
		CARL R. SAUCA/SON 11262 LEWISTOWN ROAD	
Ore, M ore, M jes 1 and 2 1 of Health if itsm 27		20a. Method of Disposition 20b. Place of Disposition (Name of	Date 20c. Location - City or Town, State
imor Pages nent of ury or o		Figure 2 Cremation 3 Premoval from State	/18/2006 CORDOVA, MD
Baltimore, permit, Pages 14 Department of He important; if item any injury or other	ġ	21. Signature of Funeral Service Licensee  22. Name and Address of Facility  PET LOGG HET PENDER.	IN & NEWNAM FUNERAL HOME PA
m goss	a	30HOK, MERCERON 200 S. HARRISON ST	T EASTON, MD 21601
		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line.	Interval Between
Physicia /Medica		Immediate Cause (Final disease or condition resulting in death)  a. House Myolandial	Lataletion
Examine		Due to (or as a consequence of):	Disease Onser and Death
4	e e	Sequentially list conditions, if any, leading to immediate b.  Due to (or as a consequence of):	Distance.
cuted	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	
60, be exacuted icien and burial-transit		resulting in death) Last Due to (or as a consequence of):	
Box 68760, eath certificate be executed ettending physicien and for use as the burial-transit	dical	d	
X 6 certific ding p	/Me	IF FEMALE: 23c. If yes, outcome of pregnancy	and Date of delivery
Bo leath etten f for u	cian	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 M No    23b. If yes, outcome of pregnancy in the past 12 months?  4  Pregnant at time of death    5  Other (specify)	23d. Date of delivery  Month Day Year
P.O.	Physician/Medi	9 Unknown	
Cords, Paw requires that s been signed b	by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?
ouid I	ted	Using I hup Hant Pailing	1  Yes 2 No 3 Probably 4 Attnknown
lecc lawr las be	Completed		24a. Was an autopsy autopsy 24b. Were autopsy findings available prior to completion of cause of
The The	S		performed? death? 1 ☐ Yes 2 ☐ No
Vital Rec sicien: The law s certificate has t	Be	examiner?	eath (Check only one)
of Phys or this praid	2	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at	Home 5 ☐ Residence 6 ☐ Other (Specify)  28d. Describe how injury occurred
ion nding ath. r: Afte	atlo	1}∕SNatural 5 □ Pending (Month, Day Year) Injury Work? 2 □ Accident investigation M 1 □ Yes 2 □ No	
Division of Vital Records, P.O. to Attending Physician: The law requires that the deficit death.  Director: After this certificate has been signed by the 1 in by the funeral director, page 2 should be detached	Certification:	3 Suicide 4 Homicide  6 Could not be determined  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number. City or Town, State)
Dital o			
Division of Vital Records, P.O. Box 6870 To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours effer death. To the Funstel Director: After this certificate has been signed by the ettending physicompletely filled in by the funeral director, page 2 should be detached for use as the toompletely filled in by the funeral director, page 2 should be detached for use as the toompletely filled in by the funeral director, page 2 should be detached for use as the toompletely filled in by the funeral director, page 2 should be detached for use as the toompletely filled in by the funeral director, page 2 should be detached for use as the toompletely filled in by the funeral director, page 2 should be detached for use as the toompletely filled in the funeral director.	Medical	29a. Certifier  (Check only one)  Check only one one of examiner: On the basis of examination and/or investigation, in my opinion, death occur and manner stated.	ce, and due to the cause(s) and manner as stated. curred at the time, date and place, and due to the cause(s)
To th within To th compl	Me	29b. Signature and title of certifier 29c License number	29d. Date signed (Month, Day, Year)
		1.7. NA-60 W US1546	10/15/2006.
10-		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  19natius Dinardo, MD 2165, Weshington St. Eastw	m, mD 21601
/ O - S	State		m., mD 21601

			For State	State o	f Marylan	•	artmer			and Mental		ene . No. 2	06	31.	772
			Registrar  1. Decedent's Name (First, Middle	, Last)			71111041	0 0, 2			of Death		UU	3. Time of	Death
	Physicia			Salisbury	7					Octo		L8, 200	Year )6	7:4	5 A M
	/Medic Examin		4a. Facility Name (If not institution	, give street and nu	mber)		4b. City	Town, or	Location of	of Death		4c. County	of Death		
	Lxamiin		7053 Lennox Aver	nue			E1kr	idge				Howard			
	Funeral		5. Social Security Number	6. Sex 1 X M 2 ☐ F	7. Age (In yrs.	_	) If Unde Months	r 1 Year Days	If Under Hours	Min. (Mor	of Birth oth, Day, Y	ear)	9. Birthr	place (State ontry)	or Foreign
н	Director		317-20-4449		84	Yrs.				Feb.	28,	1922	Indi	Lana	
	and		Usual Residence of Decedent  10a. State 10b. County		10c. City	y, Town or L	ocation						1	0d. Inside C	ity Limits
	Manyl f sho	ō	Marral and Harran	3	Filer	idge								1 🗌 Yes	2 XNo
	the 28s	rec	Maryland   Howard	1	LILKI	Luge	10f. Zi	Code			100	. Citizen of W	hat Cou	ntry?	
	h with	O E	7053 Lennox Aver	nue			210	75			Ţ	JSA			
	deat	Funeral Directo	11. Marital Status	12. Was Dec	edent Ever in U.	.S. 13	. Was Dece	dent of His	spanic Ori	gin? (Specify Yes	s or No- etc.)		- Americk, White,	can Indian, etc.	
9	or it		1 ☐ Never Married 2 ☑ Marr	If Yes, Gi	2 □ No ve		1 🗆 Yes	2 <b>∑</b> No	Specify:			Specify.	LTh 4 4		
21215-0036	within 72 hours after death with the Maryland ene. Then "natural", or Items 23a or 28a-f show the Madical Examiner must be notified at	ed by	3 ☐ Widowed 4 ☐ Divorced		ates: 1943-		edent's Usu	ial Occupa	ition		16	b. Kind of Bu			
7	in 72	Completed	(Specify only highe	st grade completed)		(Giv	e kind of w	ork done d	luring mos	t of working				,	
212	iene The	E	Elementary/Secondary (0-12)	College (	1-40r 5+)	Busin	ess 0	wner			S	ign Pa	inti	ng	
ק	be filed within 72 hours after death with the Marylan Hygiene.  de Hygiene, de chter than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Bec	17. Father's Name (First, Middle,	Last)						er's Name (First,			Θ)		
<u>Jar</u>	ould be Mental arked o	ToE	Lawrence Lester	Salisbur	У					Myrtle					
Maryland	permit. Pages 1 and 2 should be Department of Health and Mental Important: if Item 27 is marked any injury or other traumatic ev any injury or other traumatic ev		19a. Informant's Name/Relations Ronald K. Salis							er or Rural Route 1kridge,			State, Zip	Code)	
e,	1 and Health em 27 ther t		20a. Method of Disposition	July/ John	20b. F	Place of Disp	position (Na	me of	1	Date		c. Location -	City or T	own, State	
Jo	ages nt of l t: # it		1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S	3 Removal from	State	cemetery, cr	ematory or	other place		10/19/06	5 Ве	eltsvi	lle.	MD	
Baltimore,	nit. Partme		21. Signature of Funeral Service		//					ty ation Se	***				
Ba	Department Department Important in any ir		1 Bowerd ?	I the W	the mo	1251E	oing	Home	Heck	rotte, I	P.A. (	Clarks	7111	. 704	21029
			23a. Part 1. Enter the disease, or shock, or heart failure. List	r complications that	caused the deat	th. Do not e	nter the mo	de of dying	g, such as	cardiac or respir	atory arres	t,		Approxima Interval Be	te tween
	Physician		Immediate Cause (Final disease or condition		Stage He	epato-	Cellu	lar (	Cance	r				Onset and	Death
1	/Medical		resulting in death)	a.	(or as a conseq				-						
	Examiner		Sequentially list conditions,	ь. Нуре	rtensio	n								years	
	p is	Examiner	if any, leading to introducto cause. Enter Underlying Cause (Disease or injury	2	(or as a conseq										
	and I-tran	хап	that initiated events resulting in death) Last	c. Atri	al Fibr	illati quence of):	Lon						=	years	
8760,	cate be executed obysicien and the burial-transit	cal E		d Peri	pheral '	Vascu]	lar Di	seas	e					years	
687	tificate ig physas the	B		0											
Box	anding use a	N/M	IF FEMALE: 23b. Was decedent pregnant		utcome of pregnation		Ectopic	Yeanancy				23d. Dat		-	
	death	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No		nant at time of o		Other (s					Moi	ntri	Day	Year
P.O.	res that the death certifi igned by the ettending be detached for use as	Physician/M	9 Unknown						an in Dart	23	e Did toba	icco use conti	ribute to	the cause of	death?
	The law requires that the death certificate be executed the has been signed by the ettending physicien and orgo 2 should be detached for use as the burial-transit	þ	Part II. Other significant conditions Cerebral Vasc	-								2 □ No			
Ö	w require been si should t	etec									a. Wasan	24h 1	Nere aut	opsy findings	savailable
Records,	has l	Completed	Rhinitis								autopsy	ed?	orior to co death?	ompletion of	cause of
		ပို	25. Was case referred to medica	1			- 000	96	26 Plac	e of Death (Chec			∐ Yes	2□ No	
Ξ	Physician: r this certific ral director,	To B	examiner? 1 Yes 2 No	Hoopital	Inpatient 2	] ER/Outpati	ient 3 🗆 🛭	Oth		ursing Home 5]	-		er (Spec	ify)	
o	ਰੂ ਦੁਲ		27. Magner of Death	28a. Date	of Injury nth, Day Year)	28b. Time Injury		28c. Injun Worl	y at			v injury occurr			
joi	Attending r death. ector: After y the fune	atio	2 Accident	igation			М	1 🗆	Yes 2 □						
Division of Vital	or Attendifier death	ertification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	mined 280. Place	e of Injury - At h ding, etc. (Speci		street, facto	ry, office			cation (Stre y or Town,	eet and Numb State)	er or Rui	ral Route Nui	mber,
	Hospital o 14 hours aff Funerel Di tely filled ir	O	29a. Certifier 1 💢 Certifyi	ing Physician: To the	a hest of my kn	owledge de	ath occurre	d at the tin	ne date a	nd place, and due	e to the cau	use(s) and ma	inner as	stated.	
	To the Hospital or Attent within 24 hours after deatl To the Funeral Director: completely filled in by the	dical	(Check only 2 Medica one)	I Examiner: On the	basis of examining the party of	ation and/or	investigation	n, in my o	pinion, de	ath occurred at th	e time, dat	te and place,	and due	to the cause	(s)
	within To the	Me	29b. Signature and title of certiff	7.	. //	/	1. 1 2	9c. Licens	e number		29	d. Date signe	d (Month	, Day, Year)	
			> all	en 1a	ill	911	1P	5474	9		0c	tober	18,	2006	
-4	20		30. Name and address of person	who completed car	use of death (It	23a) (Typ	e, Print)	\ 1 T	- ما م	niok MD	2170	1			
シ	00		Allen Reilly,		TOLL H		AVe.	)—I F	rede	LICK, MID	21/0				·· <u>·</u>
	St Regist	ate rar			Colors Sign		Cornes	,							

State of Maryland / Department of Health and Mental Hygien 006

1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Alice May Ash Swann 17, October | 2006 5:00 a /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b, City, Town, or Location of Death Examiner Carroll Long View Nursing Home Manchester Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Months Days Hours 1 ☐ M 2 🛣 F Director 214-18-6051 85 Aug 31, 1921 Maryland Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other then "naturel", or items 23a or 28a-f show other traumatic event, the Mudical Examinar rount by notified at Carroll Westminster 1 ☐ Yes 2 No Directo Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 112 Highland Road 21157 USA death Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after one of Health and Mental Hygiene.
ant: If item 27 ie marked other then "naturelt, or item ury or other traumatic event, the Medical Examination 1 ☐ Yes 2 X No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: by Specify: white 3 XWidowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 8 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Oscar Robert Benjamin Mable LaRue Charles ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 116 Highland Road, Westminster, MD 21157 Carolyn L. Bankert, daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 MBurial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Depertment of Important: If any injury or 2005. Lake View Memorial 10/20/2006 Sykesville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Myers-Durboraw Funeral Home 21. Signature of Funeral Service Licenses M01191 91 Willis Street, Westminster, MD 21157 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that is a leading to the cause). Due to (or as a consequence Examiner ettending physician and for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ♠ No Month Day Year 5 Other (specify) 4☐Pregnant at time of death ed by the e 9 Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 Ho 3 Probably 4 Unknown should b Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an rector, page 2 s autopsy performed? 2 10 No 1 ☐ Yes To the Hospital or Attending Physician: director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 🗌 Inpatient 2 ER/Outpatient 3 DOA After this funeral dir 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending death. thin 24 hours after death.
the Funaral Director: A investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) WIL 125443 6 Rd Westminster 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 18 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Day **Physician** MAUDE TURNER OCTOBER 2006 2355 14. /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner MONTGOMERY SILVER SPRING HOLY CROSS HOSPITAL If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 🗓 F 75 01 - 27 - 1931GUYANA, SA Director 140-32-5450 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State items 23a or 28a-f show iner must be notified at tyE Yes 2 □ No MD PRINCE GEORGE HYATTSVILLE Director 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 20783 U.S.A. 6511 MEDWICK DR Funeral death 14 Race - American Indian 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. Examiner permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or iter any Injury or other traumatic event, the Medical Examiner once. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Specify: BLACK Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No ģ 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) REGISTERED NURSE PRIVATE 4yrs 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ROSALINE M JOHNSON WILLIAM T. EMBRACK 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 6511 MEDWICK DR HYATTSVILLE, MD 20783 CRYSTAL R. HENDERSON/DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 20a Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State FT. LINCOLN CEMETERY 10-20-2006 BRENTWOOD, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility JB JENKINS FUNERAL HOME 21. Signature of Funeral Service Licensee 7474 LANDOVER RD LANDOVER, MD 20785 23a. Part1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. Listenly one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final SEPSIS Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** BILATERAL PNEUMONIA Sequentially list conditions, if an leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed the burial-trai Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 3 ☐ Ectopic pregnancy Month Year Day 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2X No death? 1 ☐ Yes 2X No director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2X No 1 XInpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? (Month, Day Year) 5 Pending investigation 1X Natural M 1 ☐ Yes 2 ☐ No after death. 2 ☐ Accident the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined filled in by 4 Homicide 24 hours a 1 2 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely

within 2 State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JANNA LACHTCHININA, MD 1500 FOREST GLEN RD SILVER SPRING, MD 20906

and manner stated

31. Date filed (Month, Day, Year)

29b. Signature and title of certifie

OCT 1 8 2006



Registrar

29c. License number

D64024

29d. Date signed (Month, Day, Year)

10-16-2006

			1 - State Registrer	State	e of Mary	land / De	partment of H ertificate of I	lealth and Death		iene2 () ()	6 34781
	Physici /Medic		1. Decedent's Name <i>(First, Mide</i> Ingr		a Thom	as			2. Date of Death OCTO be	Day 2, 20	3. Time of Death 2:20 A M
	Examir		4a. Facility Name (If not institution Doctors Co			a1	4b. City, Town, or Lanham	Location of Deat	h	4c. County of D	
	Funeral Director		5. Social Security Number 579 92 8792	6. Sex 1 ☐ M 2√		yrs. last birthda 44 Yrs.	Months Dave	If Under 24 Hrs Hours Min.	8. Date of Birth	961	Birthplace (State or Foreign Country) Wash.,D.C
	Maryland f ahow	or	Usual Residence of Decedent  10a. State 10b. Count  D. C.	y	10	c. City, Town or Washin					10d. Inside City Limits 1t Yes 2 No
death with the Maryland	th with the P 23a or 28a-	al Director	10e. Street and Number 2613	10f. Zip Code	20018	10	og. Citizen of What	21			
200	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "naturel", or items 23s or 28s-1 show any injury or other treumatic event, its Madical Examination must be motified at any injury or other treumatic event, its Madical Examination must be motified at angles.	by Funeral	11. Marital Status  1 X Never Married 2 ☐ Ma 3 ☐ Widowed 4 ☐ Divorce	rried 1 TY	Decedent Eve d Forces? 'es 2 No i, Give or Dates:	r in U.S. 1	3. Was Decedent of Hilf Yes, specify Cuba	ispanic Origin? (S in, Mexican, Puer Specify:	specify Yes or No- to Rican, etc.)	Black, W	merican Indian, /hite, etc. Black
00-6121	filed within 72 hours after Hygiene. sther than "nature!, or ite ent, ite Medical Examire	Completed	15. Decedent's Education (Specify only highest grade completed)  Flementary(Secondary (0.12)  College (1.4cr.5.)				cedent's Usual Occupa ve kind of work done of DO NOT use retired ector of T	during most of wo. ()	rking	American	
ומוות ל	iould be filed to Mental Hygis harked other hatic event, It	To Be Co	12years 17. Father's Name <i>(First, Middle</i> Rando1		rears			_	ne (First, Middle, M Glynnora	faiden Sumame)	
, Mai	and 2 sho fealth and h m 27 is ma		19a. Informant's Name/Relation Kevin Hall / E			520	7 12th. St		ashington	,D.C.200	11
	permit. Pages 1 Department of H Important: If ite any injury or ot		20a. Method of Disposition  1	Specify)	rom State	cemetery, c	position (Name of rematory or other place Mem. Park		7/2006 L	andover,	Maryland
מ	Depa Impo any ir		Jucen	Smel	le		22. Name and Addres 3015 12th.	ST,N.E.	WASHINGT	ON, D.C.	20017
	Physician /Medical		23a. Part1. Enter the disease, of shock, or heart failure. Lis Immediate Cause (Final disease or condition resulting in death)	t only one cause	on each line.	4	ryttmer			sst,	Approximate Interval Between Onset and Death
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	4	-	29b. Signature and title of certifi	) M.	0,		29c. License	6054		Od. Date signed (Miles)	Sinit, Day, Year)
4	8		30. Name and address of personal file Mirror 31. Date filed (Month, Day, Yea.				e, Print)	Link	on, Mr	20706	7 3
	Sta Registr		OCT 1	7 2006	A STATE OF THE STA	orginature .	h Rock				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amended Item 19a Per F.D. 10/26/2006 Carroll County, will
State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No.-2 Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Thomas 21:50 M Debra Lee 2006 10 5 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Maryland Baltimore University of If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Jumber 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 ☐ M 2 ☑ F Yrs. Director 216-66-1279 53 October 1, 1953 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ehow edical Examinar must be notified at 1 ☐ Yes 2 ☐XNo MD Carrol1 Westminster Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or 2233 Old Washington Road 21157 death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married ō Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: δ White 3 ☐ Widowed 4 ☐ Divorced 'netural' Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Jos. A. Bank Elementary/Secondary (0-12) College (1-4or 5+) Il Hygiene. Clothiers 12 Customer Relations Manager 18. Mother's Name (First, Middle, Maiden Sumame, 17. Father's Name (First, Middle, Last) permit. Pages 1 end 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any linity or other traumatic event 2008. Be Humphrey May Frances Delores Lohn 19a. Informant's Name/Relationship (Type, Print)
James R. Thomas, Jr. - Husband 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2233 Old Washington Road Westminster, MD 21157 James R. Thomas 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 10/20/2006 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Carroll Cremation, Inc Hampstead, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Pritts Funeral Home and Chapel, P.A. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 21157 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cardio respiration Physician 30 minules /Medical Due to (or as a consequence of): Examiner SCOSIS severe Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Multible or Attending Physician: The law requires that the death certificate be executed 5 weeks injunes Due to (or as a consequence of): attending physician Box 68760 by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 No 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 1 ☐ Yes 2 No 1 Yes 2 No is after deam.
Its after this ceruit.
It is by the funeral director, pr 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1XYes 2 □ No Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 Natural 5 Pending investigation Motor Cycle coash ,10,2006 1 ☐ Yes 2 No 4:42P 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Street Old Washington Road Westminster To the Hospitel within 24 hours a To the Funeral Completely filled Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical critical care fellow 29b. Signature and title of Pertifier 29c. License number 29d. Date signed (Month, Day, Year) 10/16/2006 P17629 NOT 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 Asser ousset 22South Greene Street Baltimore, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Glow It Sperter OCT 2006 Registrar

Amended Item 31 per Carroll County, 10/17/2006 wil

06-07600 Please Type or Print in Black Indelible Ink Byron Pineda State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar Amend#1, Per MFO PC 10-19-06cr Reg. No. 2. Date of Death Plfysician/ BYRON RODOLFO VALENZUELA Medical Examiner 2000 hrs October 8, 2006 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Prince George's County Hospital Cheverly Prince George's 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DO/YYYY) 9. Birthplace (State or **Funeral** Months Days Hours Director 27 Countr@uatemala None 1 XM 11/16/1978 2 F Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits or 28a-f show 1 X Yes 2 No dother than "natural", or items 23a or 28a-f sho, the Medical Examiner must be notified at once, Director Prince George Beltsvilla 10e Street and Number 10g. Citizen of What Country? 4807 Naples Ave. 20705 Guatema1a Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Never Married 2 Married 2 X No Yes 3 Widowed 4 Divorced If Yes, Give Year 1X Yes 2 No specify: Guatemala Hispanic ģ 15. Decedent's Education (Specify only highest grade completed) 16a. Oecedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) MD 21215-0036 Crane Operator Construction marked other 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Prospero de Jesus Valenzuela traumatic event, Be Martha Lidia Cante Hernandez ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) iten 27 is Pages I and 2 sl ment of Health ar tant: If item 27 or other trauma 1 aw 4807 Naples
20b. Place of Disposition (Name of cemetery, <u>Leonel</u> Ramirez/Broth/in Beltsville, Md 20705 Ave 20c. Location - City or Town, State permit Pas.
Department of portant: If it crematory or other place) 1 X Burial 2 Cremation 3 Removal from State General Cemetery 10/22/06 Oonation 5 Other Specify: Guatema1a Signature of Funeral Service Licensee 22. Name and Address of Facility Murray Funeral Home 4804 Georgia Ave. NW Washington D.C. 20011 23a. Part I. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Approximate Interval Between Onset and /Medical Death a. Head Injuries Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of). Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): Examiner (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit Physician/Medical UNPENDEO AMENDEO ending physician use as the burial -23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Fetal death 3 Ectopic pregnancy Day Year Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Oid tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown pe Completed Records, 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? page Yes 2 No 1 🗸 Yes of Vital To the Hospital or Attending Physician: director. 25. Was case referred to medical 26.Place of Death (Check only one Be examiner? Hospital: 1 Inpatient 2 V ER/Outpatient 3 Other<sub>4</sub> DOA Nursing Home 5 Residence 6 Other: 1 🗸 Yes 2 No 28a. Date of Injury (Month Day,Year) Oct 8, 2006 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? Certification: Occupant auto auto collision Natural 1807 hrs 5 Pending 1 Yes 2 V No 2 🗸 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be or Town, State) Kenilworth Avenue, Cheverly, MD determined (Specify) Major Road 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

State Registrar

Patricia Aronica-Pollak MD. 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a)

29b Signature and title of certifier

Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Registrar's Signature

ÓRIGINAL

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

October 9, 2006

hysici		1. Decedent's Name (First					711100	ile of L	Death	Mor	of Death	Day	2 006	3. Time of Dea
/Medic xamin		4a. Facility Name (If not in	stitution, give	street and nu	mber) 405PITA	41	1	y, Town, or	Location of D		OIJEN	4c. Cour	nty of Deat	th
neral ector		5. Social Security Number 218–22–3096	6. Se		7. Age (In yrs. <b>79</b>			er 1 Year	If Under 24 I	fin. 8. Date (Mor.	of Birth oth, Day, Y 7,	1927	9. Birt	thplace (State or For buntry) YLAND
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WAGNER, JAMES

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ξ	Physician: this certificatal director, I	Be c	25. Was case referred to medic examiner? 1 Yes 2 No	Hospital:	Inpatient 2 E	R/Outpatie	nt 3 DOA Oth			Check only one 5 ☐ Reside		har (Specifi	4)
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ion	Attending I r death. ector: After by the funer	atio	1 ☑Natural 5 ☐ Pend 2 ☐ Accident inves	ding (Mor stigation	ith, Day Year)	Injury		k? Yes 2□	No				
Division	Atte er dez recto by th	Certification;	3 ☐ Suicide 6 ☐ Coul 4 ☐ Homicide dete	d not be mined 28e. Place build	e of Injury - At hon ling, etc. (Specify)	ne, farm, st	reet, factory, office		28	f. Location (Sti City or Town	reet and Num , State)	ber or Rura	l Route Number,
	tal or rs afte al Dir	Cer	Building, see (opcory)							- 584			
	To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate his completely filled in by the funeral director, page	edical	29a. Certifier 1 ☐ Certify (Check only 2 ☐ Medic	ring Physician: To the al Examiner: On the b and mar	e best of my know pasis of examination oner stated.	rledge, dear on and/or in	th occurred at the tin rvestigation, in my o	ne, date an pinion, dea	nd place, an oth occurred	d due to the call I at the time, da	use(s) and mate and place	anner as st , and due to	ated. the cause(s)
	Vithin Fo the	Me	29b. Signature and title of certif			. 0	29c. Licens	e number		29	9d. Date sign	ed (Mgnth, i	Day, Year)
	->-0		▶ Wels	lan &	Hom	06/0	D D	0871	15		10/1	6/06	
	1 _ 1	1	30. Name and address of person	on who completed cau	se of death (Item:	23a) (Type	, Print)	P P			,	1	
(_/	STIVA		WILLIAM H. W				MANS LANE	, EAS	STON,	MD 2160	01		
		ate	31. Date filed (Month, Day, Yea		Registrar's Signatu		and I						
	Regist	rar	OCT 1 8	ZUUD	and di	12							

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. amend item 10b c per fit 3861 11 2206 years Mental Hygiene () () 6 34786 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year 6:30 Am 30 2006 Bernard Ayers 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Casing ( Corners, 9217 Allensword Rd Randallstown Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex Days 1 M 2□ F Months Hours Maryland 85 219-16-7343 Oct 14 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Baltimor 1 ☐ Yes 2 X No Randalls 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? U.S.A. 921.7 Allenswood Rd 21233 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Black 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Truckence Truck Driver unimoun 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ALFRED Ireland 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Allenswood, Rundallstom, mo 21133 Leola Williams 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Dundalk. NOV 1, 7006 Day Wew Crematory 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Ronald A. Grayson Fundal Service \$301 Charmel Drive Ballo md 21244 Renald attrager 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate nterval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) neumono Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2K No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 🗆 Yes e No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 XNo 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death

Physician /Medical Examiner is certificate has been signed by the attending physician and director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760. this filled in by the funeral or Attending death. Director: after To the Hospital o within 24 hours af To the Funaral Di

Examiner Physician/Medicai ģ Completed Be ဥ Certification: Medical

**Physician** 

/Medical

Examiner

10a. State

MD

Funeral Director

Completed by

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Itams 23s or 28s-f show important: If Item 27 Is marked other than "natural", or Itams 23s or 28s-f show any lyury or other traumatic evant, The Medical Examinar must be notified at

Saltimore, Maryland 21215-0020

29b. Signature and title of certifier

2 2006

Year)

0

5 Pending

2 ☐ Accident

4 Homicide

(Check only

31. Date filed (Month,

3 ☐ Suicide

investigation

6 Could not be determined 1 🗠 certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

2 Medical Examiner: On the basis of examination and/or Investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hom monds man M.

32 Registrar's Signature

State

Registrar

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours effer death.

To the Funeral Director: After this certificate has been signed by the attending physicien and Division of Vital Records, P.O. Box 68760,

	Registrar  1. Decedent's Name (First, Midd	dle, Last)				Death	2. Dat	e of Death	. No.		3. Time of Death
an	Regina J. An						Oct	ober	Day 2	$00^{\text{Year}}$	10:30 AMM
al	4a. Facility Name (If not institution		umbar)		4b. City, Town, o	or Location of C		ODCI		ty of Death	
er			umberj				Joan		40. <b>G</b> 00011	iy or Deali	
	720 S. Ponca 5. Social Security Number	Street 6. Sex	7. Age (In yrs.	lact hirthday		lf Under 24	Hrs R Dat	e of Birth		O Right	andrea (State on Francisco
	236-84-7067	1 M 2 H F	62	Yrs.	Months Days		Min. (Mo	nth, Day, Y	<sup>(ear)</sup> 1944	MD	nplace (State or Foreign untry)
										10d. Inside City Limits	
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ě	10e. Street and Number				10f. Zip Code			100	. Citizen of	What Co	untry?
Funeral Director	720 S. Ponca S	Street			21224				USA		
e	11. Marital Status	12. Was De	cedent Ever in U.	.S. 13.	Was Decedent of I	Hispanic Origin	? (Specify Ye	s or No-			ncan Indian,
2	1 Never Married 2 Ma	If Yes G	2 🔀 No		1 ☐ Yes 2 ☒ No		-ueno Alcan, e	ыс.)	Speci	ack, White	etc.
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د	17. Father's Name (First, Middle			wait	1033	18. Mother's	Name (First,				
10 De	Santo Serio					Mary H	Hilton				
-	19a. Informant's Name/Relation	nship (Type, Print)		19b. Mail	ing Address (Street			Number, C	City or Town	n, State, Z	ip Code)
	Karen Henry/da	aughter		4807	B Tennes	see St	. South	ı Char	lesto	n,WV	25309
	20a. Method of Disposition 1 Burial 2 Cremation			Place of Disp	osition (Name of ematory or other pla		Date				Town, State
	4 ☑ Donation 5 ☐ Other (		7	2	2. Name and Addre	ess of Facility			_		
	21. Signature of Euneral Service Ronal d	S. Vale	Director	r S B	2. Name and Addre tate Anat altimore,	omy Bo MD 21	ard 655 201	5 W. I	Baltin	nore	Street
	23a. Part1. Enter the disease, shock, or heart failure. Lis	or complications that st only one cause on	caused the deat	h. Do not er	nter the mode of dyi	ng, such as ca	rdiac or respir	atory arres	t,		Approximate Interval Between
	Immediate Cause (Final disease or condition	. C	maest	. , ,	Heart	Faci	14.4				Onset and Death
	resulting in death)	Due to	(or as a conseq	uence of):							
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			1 - Stata Registrar		Cei	rtificate of	Death	Re	g. No.2 U U 6	34788
	Dhysiei		1. Decedent's Name (First, Middle, Las					2. Date of Death Month	Day Year	3. Time of Death
	Physicia /Medic		Beatrice	A. Austin				oct,	30,2006	8:00PM
	Examin	er	4a. Facility Name (If not institution, give		ATOLES		or Location of Death	21.004	4c. County of Deat	
			SALISBURY REHAB  5. Social Security Number 6. S	& NURSING CE		If Under 1 Year		8 Date of Birth	WICOM 9. Birt	hplace (State or Foreign
	Funeral Director			□м ЖЖ  87	Yrs.	Months Days	Hours Min.	May 7,	Year) Co	ryland
	PL .		Usual Residence of Decedent	100 6	ty, Town or Lo					10d. Inside City Limits
	urs after death with the Maryland at', or Items 23a or 28a-1 show Exanicer must be notified at	ō	10a. State 10b. County  MD Baltim			erstown				1 ☐ Yes XXNo
	the N 28a-f	by Funeral Director	10e. Street and Number	.ore	KCISU	10f. Zip Code		10	g. Citizen of What Co	ountry?
	3a or	i Di	207 Loghouse	Wav		1	1136		U.S	
4	death	ner	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	.S. 13.	Was Decedent of I	Hispanic Origin? (Sp pan, Mexican, Puerto	ecify Yes or No-	14. Race - Ame Black, Whit	
S 8	or ite	y Fu	1 Never Married 2 Married	1 ☐ Yes X X No	i	1 □ Yes <b>X2X</b> No		7 11041 11 01017	Specify: Wh	
A∪36	72 hours after dea "natural", or Items	q pa	XXWidowed 4 □ Divorced  15. Decedent's Ed	Year or Dates:	163 Doco	dont's Heural Occur	nation		6b. Kind of Business/	
		Completed	(Specify only highest gra	ade completed)	(Give	kind of work done DO NOT use retire	pation during most of work ed)	ing	ob. Killd of business	industry
212	d with giene.	mo	Elementary/Secondary (0-12)	College (1-4or 5+)		Homema\	cer		Own H	ome
od D	al Hyg	Bec	17. Father's Name (First, Middle, Last)	1			18. Mother's Nam	e (First, Middle, M	laiden Sumame)	
Yan Yan	Menta Menta arked	To	Elmer F. Sch	naefer				ia A. G		
Baltimore, Maryland 2121	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than eny injury or other traumatic event, Item Magnee.		19a. Informant's Name/Relationship (			•			City or Town, State, 2	
6,	1 and Health em 27 ther t		Dorothy Gregg ,			sition (Name of matory or other pla	graph Rd		on, MD 2	
(각 ig	ages int of t: If It		XXBurial 2 Cremation 3 4 Donation 5/2 Other (Specif	JRemoval Irom State	Ever	areen	1		- OSO 15	1,000
, ‡	nit. Partme		21. Signature of Jun ral Sarvice Licer		1emori	al Garo	dens II	/4/06 L khardt 1	Finksbur Funeral C	hapel P.A.
B	Depa Impo eny is		I tuckner.	June						11s,MD2111
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the deal one cause one	th. Do not ent	er the mode of dy	ing, such as cardiac	or respiratory arre	st,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition		0716	~ _				Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consec		,				
1	LXammer	-	Sequentially list conditions,	b. Due to for as a consec	Party of):	un				rear.
	ecuted and -transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	The same						201-
ó	execunand and iai-tra	Exai	that initiated events resulting in death) Last	Due to (or as a consec	quence of):	40		,		201-7
760	ysicia y bur	cai	(	⊾ d						
Box 68	Attending Physicien: The law requires that the death certificat readth:  •tdor: After this certificate has been signed by the attending phy by the funeral director, page 2 should be detached for use as the	Ned	IF FEMALE:							
õ	ath ce ttendi or use	by Physician/Med	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregn. 1 ☐ Live birth 2 ☐ Feta	al death 3	Ectopic pregnanc	су		23d. Date of de Month	livery Day Year
o.	the a	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time of o	death 5L	Other (specify)		11175/A1661-74 8747-675		
۵.	that the ed by detac	, Ph	Part II. Other significant conditions of	contributing to death but not res	sulting in the u	nderlying cause g	ven in Part I.	23e. Did tob	acco use contribute to	the cause of death?
ds	puires n sign ald be	d b						1 ☐ Ye	s 2 <del>□ 10</del> 3 □ Pi	robably 4 Unknown
3	s beer	Completed						24a. Was ar	24b. Were as	utopsy findings available completion of cause of
æ	The la	mo						autopsy perform 1 Yes 2	red? / death?	completion of cause of
ia	ien: irtifica ctor, p	BeC	25. Was case referred to medical examiner?				26. Place of Dea	th (Check only one		
<u></u>	hysic his ce	၉	1 ☐ Yes 2 ☑ H6		ER/Outpatier	IT 3 DOA			nce 6 Other (Spe	cify)
Ę	ling P	<u>i</u>	27. Manner of Death 1 ☑ Matural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	We	uryat ork? ]Yes 2 ☐No	28d. Describe ho	w injury occurred	
Division of Vital Records, P.O.	Attendi death. ctor: A y the fu	licat	2 Accident investigatio 3 Suicide 6 Could not b	00 Blace of Injury At h	ome, farm, st			28f. Location (Str	eet and Number or R	ural Route Number.
<u>Ş</u>	after after Direct	Certification;	4 ☐ Homicide determined	building, etc. (Speci	fy)	ost, rustory, omos		City or Town	, State)	
	To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit			hyelclan. To the best of my kn						
	in 24 the Fu pletel	Medical	(Check only 2 Medical Examone)	miner: On the basis of examina and manner stated.	ation and/or in					
	with To t	Σ	29b. Signature and title of certifier	11		29c. Licen	nse number	29	9d. Date signed (Mont	h, Day, Year)
	-	1	0000111	Lus		200	1719		10/30	166
ni I	10		30. Name and address of person who				ov Mn '	21804	1	7
	Sta	ate.	WILLIAM ROBINS, I 31. Date filed (Month, Day, Year)	2. Registrar's Sign		SWATSROF	XI, PID• Z	1004		
	Regist		NOV 0 2 200	16 Marie A	A Apple	MAS				

			For State Registrar	State of Maryland /	Depa Cer	rtment of He tificate of D	ealth and N Death		iene (	06	34789
	Physici		1. Decedent's Name (First, Middle, Last)	Augerinos				2. Date of Dear Month October	th	006	3. Time of Death
	/Medio Examir		4a. Facility Name (If not institution, give s. Anne Arundel Medic	reet and number)		4b. City, Town, or I Annapoli		<del> </del>	7	y of Death	el
	Funeral Director		5. Social Security Number 6. Sex 219-76-2962 1□	7. Age (In yrs. last i	birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day July 31	Year) 1963	9. Birthp Cour MD	plece (State or Foreign htry)
	ryland how		Usual Residence of Decedent  10a. State 10b. County	10c. City, To	own or Lo					1	10d. Inside City Limits
	or 28a-f s	Directo	Md Anne Aru  10e. Street and Number	nder An	ilia po	10f. Zip Code 21401		1	0g. Citizen of JSA	What Cour	1 ☐ Yes 2 🐧 No ntry?
036	iges 1 and 2 should be ilied within 72 hours after death with the Maryland nt of Health and Mental Hygiene.  If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Madical Examiner must be mailined at	by Funeral Director	1302 Hawkins Lane  11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in U.S. Armed Forces? 1 — Yes 2 — No If Yes, Give A Year or Dates:	"	Vas Decedent of His Yes, specify Cuban	panic Origin? (Sp., Mexican, Puerto	pecify Yes or No-	14. Ra- Bla	ce - Americ ck, White, fy: whit	can Indian, etc.
21215-0036	I within 72 ho lene. r then *natur the Medical	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) 12		(Give	ent's Usual Occupat kind of work done du DO NOT use retired) CE Manage	iring most of work	king	16b. Kind of B		dustry
Maryland 2	uld be filed lental Hyg ked other	To Be C	17. Father's Name (First, Middle, Last) Ronald V. Logue	Sr.			18. Mother's Nam Lois Hol	e (First, Middle, I dson	Maiden Sumai	ne)	
	ind 2 shoualth and N		19a. Informant's Name/Relationship (Type Lois Holdson (moth	er)	9b. Mailin 302 F	g Address <i>(Street at</i> lawkins Ln	nd Number or Ru I., Annaj	ral Route Number Dolis, Mi	21401	, State, Zip	Code)
Baltimore,	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Importants: If item 27 is marked other than 'any injury or other traumatic event, the Mance.		20a. Method of Disposition  1 ∰ Burial 2 ☐ Cremation 3 ☐ Re  1 ☐ Donation 5 ☐ Other (Specify)	moval from State Lake	viev.	sition (Name of natory or other place Memorial	11-1-	-06	20c. Location Sykesví	11e,	MD
Balt	permit. Pa Departmer Important: any injury		21. Signature of Funeral Service License Paray Jaight M	hert	22 I	Name and Address O.O. Box 1	of Facility Hat 95 Sykes	ight Fund sville, l	eral Ho MD 2178	ome & 34	Chapel
1	Physician bhysician and physician and physician and physician and physician into physician and physi	Examiner	23a. Part1. Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence)  Due to (or as a consequence)	ee of):	the mode of dying	Coul		est,		Approximate Interval Between Onset and Death
ls, P.O. Box 68760,	death certifi e attending id for use as	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   140   9   Unknown  Part II. Other significant conditions confidence.	c. If yes, outcome of pregnancy  1 Live birth 2 Fetal dea  4 Pregnant at time of death 9 Unknown	5	Ectopic pregnancy Other (specify)	n in Part I.		М	ate of deliverenth	Day Year
Il Records,	The law requate has been page 2 should	Completed						24a. Was a autops perform	n 24b. y	Were auto prior to con death?	psy findings available mpletion of cause of
of Vital	ysician is certific director,	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	spital: 1 Inpatient 2 ER/	Outpatien	Other		th <i>(Check only on</i>		ner (Specif	y)
Division o	After After fune		27. Manner Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	. Time of Injury	28c. Injury Work? M 1 □ Y	es 2 No	28d. Describe ho	ow injury occur	red	
Divis	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, building, etc. (Specify)	farm, stre	eet, factory, office		28f. Location (St City or Town		ber or Rura	l Route Number,
	To the Hospital or within 24 hours after To the Funeral Dirticompletely filled in I	Medical		cian: To the best of my knowled er: On the basis of examination and manner stated.							
	To t To t	Σ	29b. Signature and title of certifier	Hans	. m	29c. License	number 5332	6	9d. Date signe	OG.	Day, Year)
	12		30. Name and address of person was con	righted cause of death (Item 23a	a) (Type, 1		e Pd	Ste 3	00 A	nn 41	21401
	Sta Registi		31. Date filed (Month, Day, Year)	32. Hegistrar's Signature	6	sel.				4	W. /

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

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			Registrar		Certificate (	J, L	ou			F	Reg. No.	200	
	Physicia		Decedent's Name (First, Middle,Last)	st)					2. [	Date of De	ath	Year	3. Time of Death
	al Exami		r Amira Abbas , October 31, 2006 1720 hrs									1720 hrs	
			4a. Facility Name (if not institution, give	ve street and number)		4b.	City, Town, or L	ocation of De				ounty of Deat	1
-			Route 70 West at 3 mile				lancock					shington	
and the	Funeral		5. Social Security Number 6. S	ex 7. Age (In	yrs. last birthday)	-	f Under 1 Year	If Under 24	_		,	/YYYY) 9. Bii Forei	thplace (State or
E	Director		068-80-1249	M 2XF 41		rs.	Months Days	Hours N	√lin.	9-11-	-1965		ountry) Pakistan
		l l		IVI ZZZI		, , ,							·· randibani
		- 1	Usual Residence of Decedent	1400	City, Town or Loc	otion			-				10d. Inside City Limits
	' any		10a. State 10b. County										1 Yes 2 X No
	short ice.	اج	MD How	ard	E	11i	icott Ci	ity					1 Yes 2 ANO
	faryland 28a-f show 1 at once.	퓽	10e. Street and Number			1	Of. Zip Code				10g. Citizen	of What Cou	intry?
	filed within 72 hours after death with the Maryland I Hygiene. «I other than "natural", or items 23a or 28a-f sho s, the Medical Examiner must be notified at once.	Director	11026 Dorsch Fa	rm Dood			210	042			US	7.4	
	h the												
	ms 2	unera	11. Marital Status	12. Was Decedent Eve Armed Forces?			ecedent of Hisp specify Cuban,				10-	. Race - Amei White, etc.	rican Indian, Black,
	ite	ΞI	1 Never Married 2 X Marrie	1 Yes 2 X		165,	specify oddan,	Woxioaii, i oc	or to i tro	ari, oto.		TTINO, Oto.	
	ler o	ᄔ	3 Widowed 4 Divorce	d If Yes, Give Year	1	Ye	s 2 X No	specify:			Sp	ec <i>ify:</i> Othe	er Asian
	ural min	ð	15. Decedent's Education (Specify of	or Dates:	ed) 16a. Deced	ent's	Usual Occupation	on (Give kind	of work	done	16b. Kind	d of Business	/Industry
	led within 72 hours after Hygiene. other than "natural", the Medical Examiner	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)	during	most	of working life.	DO NOT use	retired)				1
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8	it en en en en en en en en en en en en en	Ē				1	Physicia						
9-0	filed with Hygiene d other	ပိ	17. Father's Name (First, Middle, Las				[1	8.Mother's Na		rst, Middle	, Maiden Su	rname)	
21	tal Fill	Be	Abbas bin A	bdul Qadir				Humi	ida				
21215-0036	Mental F marked c event, t	P	19a. Informant's Name/Relationship (	Type, Print )	19b. Mai	ling A	ddress (Street	and Number	or Rura	I Route No	umber, City	or Town, Stat	e, Zip Code)
	sho and 7 is		Feroz A. Padder,	M.D. (Spous	e) [1102	6 I	orsch F	Farm Ro	1	Ellid	ott (	lity N	ID 21042
Σ	alth		20a. Method of Disposition	Transfer (Broad	20b. Place of Dist					ate			r Town, State
ē,	ges I and 2 shou of Health and I If item 27 is r ther traumatic		1 X Burial 2 Cremation 3	Removal from State	crematory or	other	place)					•	
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돨	it. Further	1	21. Signature of Funeral Service Lice		22	ZUNan	rer and Address	p£Fiacility t	JOME	' 0 CI	JADUT.	DA (T	Box 195)
Ba	permit. Pages I and Department of Healt Important: If item injury or other trau		by I No	O		Cvl	cesville	MD C	1011E		1AFEL,	FA (1	OOX 193)
			23a. Part I. Enter the disease, or con	will be tiened the treatment the									Approximate Interval
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<b>m</b>	that the death cended by the attend	Physician/Medical	Part II. Other significant conditions	3 diministra	t not reculting in 4	חם ווחם	leriving cause o	iven in Part I		23e. Din	tobacco us	e contribute to	the cause of death?
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Sp.	requi	eg								24a. Wa			utopsy findings available completion of cause of
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II Rec	rtificate h	ပ္ပြဲ	25. Was case referred to medical					of Death (Che	eck only				
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f Vital Rec	Physician: The le er this certificate heral director, page	To Be Cor	examiner?	i inpatient			3 DOA	Other <sub>4</sub> NL	ırsing H	y one)	Residence		er: Scene
n of Vital Rec	ting Physician: The la After this certificate h funeral director, page	To Be Cor	examiner?  1 V Yes 2 No  27. Manner of Death	28a. Date of Injury		of Inju	DOA Iry 28c. Injur	Other Nury at Work?	ursing H	y one)  Home 5		occurred	er: Scene
ion of Vital Rec	ttending Physician: The latenth leath tor: After this certificate hat the funeral director, page.	To Be Cor	examiner?  1  Yes 2 No  27. Manner of Death  Natural 5 Pending	28a. Date of Injury (Month, Day Year) Oct 31, 2006	28b. Time 1716 hrs	of Inju	3 DOA iry 28c. Injur 1 Y	Other <sub>4</sub> Nury at Work?	28 Dr	y one) dome 5 d. Describ iver auto	Residence how injury	occurred Ilision	
vision of Vital Rec	or Attending Physician: The latter death birector: After this certificate h in by the funeral director, page.	To Be Cor	examiner?  1  Yes 2 No  27. Manner of Death Natural 5 Pending V Accident Investigs	28a. Date of Injury Oct 31, 2006	28b. Time 1716 hrs	of Inju	3 DOA iry 28c. Injur 1 Y	Other <sub>4</sub> Nury at Work?	28 Dr	y one)  Home 5  Id. Describ  iver auto  f. Location	Residence how injury auto co	occurred Ilision	er: Scene tural Route Number, City
Division of Vital Records,	ital or Attending Physician: The lans after death ral Director: After this certificate h lled in by the funeral director, page?	To Be Cor	examiner?  1  Yes 2 No  27. Manner of Death  Natural 5 Pending 2  Accident Investigs  3 Suicide 6 Coulerming	28a. Place of Injury ot be	28b. Time 1716 hrs	of Inju	3 DOA iry 28c. Injur 1 Y	Other <sub>4</sub> Nury at Work?	28 Dr	y one)  Home 5  d. Describ  iver auto  or Town	Residence how injury Dauto CO	occurred Ilision	
Division of Vital Rec	ospital or Attending Physician: The la I hours after death uneral Director: After this certificate h ly filled in by the funeral director, page.	Certification: To Be Cor	examiner?  1  Yes 2 No  27. Manner of Death  1  Natural 5 Pending 2  Accident Investiga 3  Suicide 6 Could not determin 4  Homicide  29a. Certifier	28a. Date of Injury Oct 31, 2006  28e. Place of Injury (Specify) Inters	28b. Time 1716 hrs - At home, farm, s tate/Express	of Inju	DOA  28c. Injur  1 Y  factory, office b	Other 4 Number of Number 2 Number of	28 Dr 28 Ro	y one)  dome 5  d. Describ  iver auto  f. Location  or Town  ute 70 W	Residence e how injury o auto co i (Street and State) est at 3 m	occurred Illision Number or File marker,	tural Route Number, City Washington County, M
Division of Vital Rec	ite Hospital or Attending Physician: The lin 24 hours after death the Funeral Director: After this certificate h pletely filled in by the funeral director, page.	Certification: To Be Cor	examiner?  1. Yes 2 No  27. Manner of Death  1 Natural 5 Pending 2 Accident Investiga 3 Suicide 6 Could not determin 4 Homicide Certifying Physics	28a. Date of Injury Oct 31, 2006  28e. Place of Injury (Specify) Inters	28b. Time 1716 hrs - At home, farm, s tate/Express	of Injustreet,	DOA  28c. Injur  1 Y  factory, office b	Other NL  ry at Work?  Yes 2 No  uilding, etc.	28 Dr 28 Ro and du	y one)  do Describ  iver auto  f. Location or Town oute 70 W e to the ca	Residence how injury of auto con (Street and State) rest at 3 m	occurred illision Number or F ile marker, v	tural Route Number, City  Washington County, Marted.
Division of Vital Rec	To the Hospital or Attending Physician: The la within 24 hours after death To the Funeral Director: After this certificate h completely filled in by the funeral director, page?	Certification: To Be Cor	examiner?  1  Yes 2 No  27. Manner of Death  1  Natural 5  Pending 2  Accident Investiga 3  Suicide 6  Could not determin  4  Homicide  Certifying Physical	28a. Date of Injury Oct 31, 2006  28e. Place of Injury (Specify) Inters	28b. Time 1716 hrs - At home, farm, s tate/Express	of Injustreet,	B DOA  Jany 28c. injur  1 Y  factory, office b  d at the time, da  n, in my opinion	Other NL  Nu  No  No  No  No  No  No  No  No  No	28 Dr 28 Ro and du	y one)  do Describ  iver auto  f. Location or Town oute 70 W e to the ca	Residence e how injury of auto co	occurred illision d Number or F ile marker, manner as sta e, and due to	tural Route Number, City Washington County, M inted. the cause(s)
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Division of Vital Rec	To the Hospital or Attending Physician: The la within 24 hours after death To the Funeral Director: After this certificate h completely filled in by the funeral director, page.	Certification: To Be Cor	examiner?  1  Yes 2 No  27. Manner of Death  1  Natural 5  Pending 2  Accident Investiga 3  Suicide 6  Could not determin  4  Homicide  Certifying Physical	28a. Date of injury Oct 31, 2006  28e. Place of Injury (Specify) Inters  ician: To the best of my kr er:On the basis of examin.	28b. Time 1716 hrs - At home, farm, s tate/Express	of Injustreet,	B DOA  Jany 28c. injur  1 Y  factory, office b  d at the time, da  n, in my opinion	Other NL  Try at Work?  Ves 2 No  uilding, etc.  Ate and place,  death occurr  e number	28 Dr 28 Ro and du	y one)  do Describ  iver auto  f. Location or Town oute 70 W e to the ca	Residence e how injury D auto CO (Street and State) lest at 3 m (suse(s) and ste and place	occurred illision d Number or F ile marker, manner as sta e, and due to	tural Route Number, City  Washington County, M  Inted. the cause(s)  onth, Day, Year)
Division of Vital Rec	To the Hospital or Attending Physician: The lawithin 24 hours after death To the Funeral Director: After this certificate h completely filled in by the funeral director, page.	Certification: To Be Cor	examiner?  1  Yes 2 No  27. Manner of Death  1  Natural 5 Pending 2  Accident Investig: 3  Suicide 6 Could not determin  29a. Certifier 1 Certifying Physical Examin  29b. Signature and title of certifier	28a. Date of Injury Oct 31, 2006  28e. Place of Injury (Specify) Intersician: To the best of my kner: On the basis of examinand manner stated.	28b. Time 1716 hrs - At home, farm, s tate/Express lowledge, death or ation and/or invest	of Injustreet,	3 DOA  iry 28c. Injur 1 Y factory, office b d at the time, da n, in my opinion 29c. License	Other NL  Try at Work?  Ves 2 No  uilding, etc.  Ate and place,  death occurr  e number	28 Dr 28 Ro and du	y one)  do Describ  iver auto  f. Location or Town oute 70 W e to the ca	Residence e how injury D auto CO (Street and State) lest at 3 m (suse(s) and ste and place	d Number or Fille marker, I manner as stee, and due to late signed (M	tural Route Number, City  Washington County, M  Inted. the cause(s)  onth, Day, Year)
Division of Vital Rec	To the Hospital or Attending Physician: The lawithin 24 hours after death To the Funeral Director: After this certificate h completely filled in by the funeral director, page.	Certification: To Be Cor	examiner?  1  Yes 2 No  27. Manner of Death  Natural 5 Pending 2  Accident Investig: 3 Suicide 6 Could not determin  29a. Certifier 1 Certifying Physone) 2  Medical Examin  29b. Signature and title of certifier  30. Nat and ddress of person wh	28a. Date of Injury Oct 31, 2006  28e. Place of Injury (Specify) Inters  ician: To the best of my kr er: On the basis of examin and manner stated.	28b. Time 1716 hrs - At home, farm, state/Express sowledge, death or ation and/or investing (Item 23a)	of Injustreet,	3 DOA  Iry 28c. Injur 1 Y factory, office b d at the time, da n, in my opinion 29c. Licens O.C.I	Other NL ry at Work?  Ves 2 No uilding, etc.  Attended place, death occurr e number  M.E.	28 Por 28 Ro and du red at th	y one) y one) dome 5 d. Describ iver aut or Town uute 70 W e to the ca ise time, da	Residence e how injury D auto CO (Street and State) lest at 3 m (suse(s) and ste and place	d Number or Fille marker, I manner as stee, and due to late signed (M	tural Route Number, City  Washington County, M  Inted. the cause(s)  onth, Day, Year)
Division of Vital Rec	To the Hospital or Attending Physician: The la within 24 hours after death To the Funeral Director: After this certificate h completely filled in by the funeral director, page.	Certification: To Be Cor	examiner?  1  Yes 2 No  27. Manner of Death  1  Natural 5  Pending 2  Accident Investiga 3  Suicide 6  Could not determin 29a. Certifier 1  Certifying Physone) 2  Medical Examin  29b. Signature and title of certifier  30. Natl and ddress of person wh Susan Hogan MD. Asset	28a. Date of Injury Oct 31, 2006  28e. Place of Injury (Specify) Inters  ician: To the best of my kr er: On the basis of examinand manner stated.	28b. Time 1716 hrs - At home, farm, s tate/Express owledge, death or ation and/or invest	of Injustreet,	3 DOA  iry 28c. Injur 1 Y factory, office b d at the time, da n, in my opinion 29c. License	Other NL ry at Work?  Ves 2 No uilding, etc.  Attended place, death occurr e number  M.E.	28 Por 28 Ro and du red at th	y one) y one) dome 5 d. Describ iver aut or Town uute 70 W e to the ca ise time, da	Residence e how injury D auto CO (Street and State) lest at 3 m (suse(s) and ste and place	d Number or Fille marker, I manner as stee, and due to late signed (M	tural Route Number, City  Washington County, M  Inted. the cause(s)  onth, Day, Year)
Division of Vital Rec	0	Medical Certification: To Be Cor	examiner?  1  Yes 2 No  27. Manner of Death  1  Natural 5  Pending 2  Accident Investiga 3  Suicide 6  Could not determin 2  Medical Examin  29a. Certifier 1  Certifying Physone) 2  Medical Examin  29b. Signature and title of certifier  30. Natl and ddress of person wh Susan Hogan MD. As:  31. Date filed (Month, Day, Year)	28a. Date of Injury Oct 31, 2006  28e. Place of Injury (Specify) Inters  ician: To the best of my kr er: On the basis of examinand manner stated  o c mplet d cause of deat sis ant Medical Exar	28b. Time 1716 hrs - At home, farm, s tate/Express owledge, death or ation and/or invest	of Injustreet,	3 DOA  Iry 28c. Injur 1 Y factory, office b d at the time, da n, in my opinion 29c. Licens O.C.I	Other NL ry at Work?  Ves 2 No uilding, etc.  Attended place, death occurr e number  M.E.	28 Por 28 Ro and du red at th	y one) y one) dome 5 d. Describ iver aut or Town uute 70 W e to the ca ise time, da	Residence e how injury D auto CO (Street and State) lest at 3 m (suse(s) and ste and place	d Number or Fille marker, I manner as stee, and due to late signed (M	tural Route Number, City  Washington County, M  Inted. the cause(s)  onth, Day, Year)

	1 - For State Registrar	_	Department of Health and Certificate of Death	Mental Hygier	7111b 34/91
Physician	1. Decedent's Name (First, Middle,			2. Date of Death Month	3. Time of Death
/Medica Examiner	And the allies and the section of th	give street and number)	4b. City, Town, or Location of Dea	th OCT 2	c. County of Death
Funeral	5. Social Security Number	3. Sex 7. Age (In yrs. last birt	hday) If Under 1 Year   If Under 24 Hr. Months Days Hours Min		9. Birthplace (State or Foreign
Director	Usual Residence of Decedent  10a, State  10b. County	, 10c. City, Town		11-6-4	10d. Inside City Limits
death with the Maryland ma 23s or 28s-f ehow Livest to notified at	A .	ARUNDE PASA	HDENA		1 □ Yes 2 Mo
ifer death with the Maintenance as a creater of the matter nutilized in creating the multiple control of the creating of the c	10e. Street and Number	WE.	10f. Zip Code 21122	10g. (	U.S.A
in in in in in in in in in in in in in i	11. Marital Status  1 Never Married 2 Marrie  3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1	13. Was Decedent of Hispanic Origin? ( If Yes, specify Cuban, Mexican, Pue) 1 ☐ Yes 2 ☑ No Specify:	Specify Yes or No- rto Rican, etc.)	14. Race - American Indian, Black, White, etc.  Specify:
ind 21215-0036 be filed within 72 hours af tal Hygiene. d other then "natural; or event, I're Medicel Exam Re Completed by I	(Specify only highest Elementary/Secondary (0-12)	s Education grade completed)  College (1-4or 5+)	Decedent's Usual Occupation (Give kind of work done during most of wo	orking 16b.	Kind of Business/Industry
trail H d off	17. Father's Name (First, Middle, L	ast)	18. Mother's Na MYRT	ame (First, Middle, Maid LE BOLT	en Sumame)
Md 2 and 2 state and 2 state and 27 ls r trau	19a. Informant's Name/Relationshi	p (Type, Print) 19b.	Mailing Address (Street and Num, er or F	Rural Route Number, City	or Town, State, Zip Code)
More, Pages 1 au nent of Hea int: If Item iry or othe	20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation	20b. Place of cemeter	Disposition (Name of y, crematory or other place)		Location - City or Town, State
Baltimore, permit. Pages 1 ar Department of Hee Important: If Hem eny Injury or othe	4 □ Donation 5 □ Other (So. 21. Signature of Eun-ya Service L	pecify)	Name and ddress of Facility Daugherty Family Funeral		Center, P.A.
4 403.4	23d. Part1. Enter the disease, ord shock, or heart failure. List o	emplications that caused the death. Do n		I - Pasadena, MD.	21122 Approximate Interval Between
Physician / /Medical	Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consequence of		of sinu	S Onset and Death Three years
Examiner	Sequentially list conditions,	b			
executed in and intransit	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c Due to (or as a consequence of	nf):		
cate be executed cate be executed physician and the burial-transit		d			
BOX 6 ath certifi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy 1	3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of delivery Month Day Year
res that the de signed by the a be detached f	1 ☐ Yes 2 Thin 9 ☐ Unknown  Part II. Other significant condition	ns contributing to death but not resulting in	the underlying cause given in Part I.	23e. Did tobacc	o use contribute to the cause of death?
Records, the law requires t e has been signe age 2 should be o				1 ☐ Yes 24a. Was an	2 No 3 Probably 4 Unknown  24b. Were autopsy findings available
The lav				autopsy performed 1 Yes 2 X	prior to completion of cause of death?
Vital Sicien: T Sicertificat Sirector, pa	25. Was case referred to medical examiner?  1  Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Ou	Other	eath (Check only one) Home 5 Residence	6 DOthar (Security)
Division of Vital Re To the Hospital or Attending Physician: The Within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page		28a. Date of Injury (Month, Day Year) 28b. T	ime of njury M 1 Tyes 2 No	28d. Describe how in	
DIVIS	27. Manner of Death  1 Natural 2 Accident investige 3 Suicide 6 Could nedeterming		rm, street, factory, office	28f. Location (Street City or Town, Sta	and Number or Rural Route Number, ate)
Divisio  To the Hospital or Attend within 24 hours after death To the Funeral Director; completely filled in by the f	29a. Certifier 1 Certifying	Physician: To the best of my knowledge xaminer: On the basis of examination and manner stated.	d/or investigation, in my opinion, death occ	curred at the time, date a	and place, and due to the cause(s)
To the within To the comple	29b. Signature and title of certifier	PAINI.	29c. License number	29d. [	Date signed (Month, Day, Year)
23	Maure	to completed course of death (to = 00)	D50498	No	vember 1, 2006
	30. Name and address of person w	Gillison M.D.	Johns Hopkin	is Huspi	tal
State Registra	MILLY D O 7	006 Aegistrar's eignature			Date signed (Month, Day, Year) events I, 2006 Fal

State of Maryland / Department of Health and Mental Hygien \( \text{O} \) \( \text{O} \)

		1- State of Maryland / Departm Certific	ent of Health and Nate of Death		en 2006	34792
Physic	ian	Decedent's Name (First, Middle, Last)		2. Date of Death	Day Year	3. Time of Death
/Med	ical	Theodore Bolden Jr.  4a. Facility Name (If not institution, give street and number)  4b. C	city, Town, or Location of Death		. 7 , 2006 4c. County of Death	2:45 PM
Exami	ner	St.Thomas More Nursing	Hyattsville		Prince G	
Funeral Director		5. Social Security Number 251-60-1244 6. Sex 1 1 ★ 2 □ F 68 Yrs. 68 Yrs.	hder 1 Year If Under 24 Hrs. This Days Hours Min.	8. Date of Birth (Month, Day, Y) Aug. 13,	earL Co	nplace (State or Foreign untry) kin, S.C.
land ow		Usual Residence of Decedent           10a. State         10b. County         10c. City, Town or Location				10d. Inside City Limits
e Mary ta-f eh	ctor	MD Prince Georges Landover				1X∑Yes 2 No
with the or 28	Funeral Director	106. Street and Number 1909 Oregon Ave.	. Zip Code 20785	10g	U.S.A.	untry?
death	nera	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was De	ecedent of Hispanic Origin? (Sp specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - Amer Black, White	
2 should be filed within 72 hours after death with the Maryland and Menial Hygiene. Is marked other then "naturel", or Items 23e or 28a-f show furmatic event, tra Madical Examinational be nuttined.	by Fu	1 Never Married 2 Married 1 Yes 2 No	s 2 No Specify:	, , , , , ,	Specify	ack
72 hou nature	eted	15. Decedent's Education 16a. Decedent's L (Specify only highest grade completed) (Give kind o	f work done during most of work	king 16	b. Kind of Business/I	
within ene. then	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	Tuse retired) Tile Sette:		Private	
al Hygi	Be C	17. Father's Name (First, Middle, Last)  Theodore Bolden Sr.	18. Mother's Nam	e (First, Middle, Ma	iden Sumame)	
hould to display the market matic	J.		ress (Street and Number or Rui			in Code)
and 2 s alith an 27 is r trau			egon Ave.Lar			,p 0000)
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "naturel", or Iteme 23e or 28a-f ehow eny injury or other traumatic event, the Madical Examinat must be notified at once.		20a. Method of Disposition  1 Deurial 2 Cremation 3 Removal from State  Lincoln Me	(Name of or other place) em.Cem.Oct.		c. Location - City or 1 Suitland	
mit. Partmet partmet portant y injury		4 Donation 5 Other (Specify)	e and Address of Facility Hu			
		Tranco B. Hunl 908	Kennedy St.N	N.W.Wash	.D.C.200	11
Dhysisian		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the shock, or heart failure. List only one cause on each line.  Immediate Cause (Final Grand Carcinoma Prostat				Approximate Interval Between Onset and Death
Physician /Medical Examiner		disease or condition resulting in death)  a. CATCTITOTICA PLOS CALC  Due to (or as a consequence of):	e with Metas	casis c	O Boile	years
LXammer		Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):				
ecuted and transit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death). Last				
Attending Physician: The law requires that the death certificate be executed it death.  •ctor: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit	dicai E	Due to (or as a consequence of):				
artificate ing phy e as the		IF FEMALE:				
leath certifi attending	ician/Me	23b Was decadent pregnant 23c. If yes, outcome of pregnancy	ic pregnancy r (specify)		23d. Date of deliment	very Day Year
ires that the de signed by the a	Physi	9 Unknown				
uires th	þ	Part II. Dther significant conditions contributing to death but not resulting in the underlying to death but not resulting in the underlying to death but not resulting in the underlying to death but not resulting in the	ng cause given in Part I.		cco use contribute to	the cause of death?  bably 4 Unknown
aw require	ompieted			24a. Was an autopsy	24b. Were au	topsy findings available ompletion of cause of
hysician: The law his certificate has b	Com			performe	d?   death?	2 No
ysiciar ysiciar is certif	To Be	25. Was case referred to medical examiner?  1  Yes 2 No  Hospital: 1 Inpatient 2 ER/Outpatient 3	Other	th <i>(Check</i> on <i>ly</i> one) ome 5 Resident	ce 6 ☐Other (Spec	erfv)
ing Phys		27. Manner of Death 1 Matural 5 Pending 28a. Date of Injury 28b. Time of Injury	28c. Injury at Work?	28d. Describe how		
Attend r death ector: by the f	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, far building, etc. (Specify)	1 Yes 2 No		et and Number or Ru	ral Route Number,
urs efte				City or Town,		
To the Hospital or Attending Phy within 24 hours effer death.  To the Funeral Director: Affer this completely filled in by the funeral to	edical	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, death occur on the basis of examination and/or investigation and manner stated.	rred at the time, date and place, tion, in my opinion, death occur	and due to the cau red at the time, date	se(s) and manner as and place, and due	stated. to the cause(s)
To th withir Comp	Me	29b. Signature and title of certifier	29c. License number DO 1852	290	8 Oct.	2006
19		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)				
4		Paul A.DeVore, M.D. 4258 Queensbur	y Rd.Hyattsv	ille,MD	.20781	
Si Regis	tate trar	31. Date filed (Month, Day, Year)  32. Regi A Signature	anti)			

			1 - For State Registrer	State of Ma	aryland		artment rtificate					ene (	306	34	793
			1. Decedent's Name (First, Middle, Last)								Date of Death		V	3. Time	of Death
	Physici /Medio		Walter H. Blake								ctober	Day 24,	2006	3:30	PM M
	Examin		4a. Facility Name (If not institution, give stre	et and number)			4b. City, T	fown, or	Location o	of Death			unty of Death		
			7405 Knollwood Roa	d				wson				Bal	timor	е	
	Funeral		5. Social Security Number 6. Sex	2 T E		ast birthday)	ff Under	1 Year Days	If Under :		Date of Birth Month, Day,	Year)	Cou	nplace (State untry)	or Foreign
	Director		069-16-3071	201	85	Yrs.				Ju]	Month, Day, Ly 15,	1921	C	<u>r                                    </u>	
	and and		Usual Residence of Decedent  10a. State 10b. County		10c. City	, Town or Lo	cation							10d. Inside	City Limits
	Marylan f show	ō	MD Baltimore		m <sub>orr</sub>										s 2% No
	28s-	ect	10e. Street and Number		100	son	10f. Zip	Code			10	g. Citizen	of What Cou	intry?	
	with Se or	by Funeral Director	7405 Knollwood Road					286				USA		,	
	Jeeth Tre 2	era		Was Decedent 8	Ever in U.S		Was Decede	ent of His	spanic Orig	gin? (Specify	Yes or No-		Race - Amer	ican Indian,	
(0	r tran	Ē	1 ☐ Never Married 2 ☑ Married	Armed Forces? 1 ☑ Yes 2 □ N If Yes, Give	lo	'	f Yes, speci	fy Cubar	n, Mexican	i, Puerto Rica	n, etc.)		Black, White	, etc.	
030	urs a	٥	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates: 1	43-4	6	1□Yes 2	K) No	Specify:			Spe	ecify: wh:	ite	
21215-0036	within 72 hours efter deeth with the Maryland ans. then "naturel", or Items 23e or 28e-f show he Medicel Examilier must be multified at	Completed	15. Decedent's Educat (Specify only highest grade of			16a. Deced	dent's Usual	Occupa	tion	t of working	1	6b. Kind o	of Business/I		
21	thin.	n d	Elementary/Secondary (0-12)	Colfege (1-4or 5	+)					t of working					
	filed wi Hygien ther th	ပ္ပ	12	ł		teach	er/lik					duca			
Maryland	d oth	Be	17. Father's Name (First, Middle, Last)							r's Name (Fir					
yla	should ind Men imarke umatic	မ	Allen Mitchell Blak							ha Eli					
Nar	2 sh and 1s m		19a. Informant's Name/Relationship (Type,	,			_			er or Rural Ro				ip Code)	
	and lealth m 27		Patricia Blake/spou	se	201 D				Roa	d Tows					
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours efter deeth with the Maryla Department of Heatih and Menial Hygiene. Importants if item 27 is marked other then "naturel; or items 23e or 28e-1 show any injury or other traumatic event, the Medical Exeminational Le notified at any injury or other traumatic event, the Medical Exeminational Le notified at another.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Rem 4  Donation 5 ☐ Other (Specify)	ovaf from State	Ce	face of Dispo ametery, crer	natory or oti	her place	)	Date	2	uc. Locati	on - City or 1	own, State	
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			23a. Part1. Enter the disease, or complicat shock, or beart failure. List only one	ions that caused	the death	. Do not ent	er the mode	of dying	, such as	cardiac or res	spiratoryarre	st,		Approxima Interval Be	ate
	Physician		Immediate Cause (Final disease or condition	A- C-4	FP	w.A.s.	1 - 1	4	1:	1 :	a la	s +	1011	Onset and	
	/Medical		resulting in death)	Due to (or as a	a consequ	ience of):	00	VW	MA	/ (/	MADE	011	001	MIN	ute
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	D #	ner	Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequ	ienge of):		(							
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8760,	ate b hysic the bi	dicai	d												
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Вох	The law requires thet the death certificate be executed sie has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	Physician/Me	23b. Was decedent pregnant in the past 12 months?	If yes, outcome of 1 ☐ Live birth	2 Fetal	death 3	Ectopic pre					23d.	Date of delive	/ery Day	Year
	the a	/sic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at 9☐ Unknown	time of de	eath 5□	Other (spe	cify)					William	Day	1041
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Sic	tend deeth tor: the t	cat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be				M		es 2 🗆 N						
Division	or Author of Direction by	Certification:	4 ☐ Homicide determined	28e. Place of Inju building, etc	ry - At not :. <i>(Specify</i> )	me, tarm, str	eet, factory,	office		281.	Location (Stre City or Town,	State)	imber or Hui	rai Houte Nui	mber,
_	pital ours s eraf I		29a. Certifier 1 Certifying Physici	an: To the hard	of man town	uladea daad		4 th = 2 =	a udot:	d alastic i	due to th	( )			
	To the Hospital or Attending Phyalcian: within 24 hours after deeth. To the Funeral Director: After this certific completely filled in by the funeral director.	Medical	29a. Certifier 1 Certifying Physici (Check only one) 2 Medical Examiner	an: To the best of On the basis of and manner sta	examinati	ion and/or inv	estigation,	in my opi	e, date and inion, deat	a piace, and o th occurred at	ue to the cau the time, dat	e and pfa	manner as ce, and due	stated. to the cause	(s)
	o the	Me	29b. Signature/and title of certifier	Sid Sid			_ 29c.	License	number		29	d. Date si	gned (Month,	Day, Year)	
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110	7)		30 Name and address of barren who	leted cause of di	ash ///	220\ / () ===	Drint)	//	1.				~ >.	00	
	5/		30. Name and address of Person who comp	10NO	5 N	17,	7'80	1 >	IORK	Rd	Ton	1501	VIM	0,21	roy
	Sta Registr		31. Date filed (Month, Day, Year) NOV 0 2 2006	32. Registra	irs Signat	ure	all 3								

State of Maryland / Department of Health and Mental Hygien UUD Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Year **Physician** Harry Η. Bennett October 30 2006 6:15a /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll Hospital Center Westminster Carroll | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Nonths | Days | Hours | Min. | Dec 27 192 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs, last birthday) **Funeral** 1 ☐ M 2 ☐ F 76 215**-**32-6651 Director MD Usual Residence of Decedent permit. Pages 1 and 2 should be filled within 72 hours after deeth with the Maryland Depertment of Health and Mental Hygiene. Depertment of Health and Mental Hygiene and Viewe 23a or 28e-f show any injury or other traumatic event, the Medical Examinal must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Md Carroll Woodbine 1 ☐ Yes 2 No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21797 USA 5313 Woodbine Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give A Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: white Completed by 3 Widowed 4 Divorced Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) carpenter construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Richard R. Bennett Jr. Katie E. Maddox 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5313 Woodbine Rd., Woodbine, MD 21797 Sue C. Bennett (spouse) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Wesley Chapel Cemetery 11-3-06 1 
☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Sykesville, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Haight Funeral Home & Chapel 21. Signature of Funeral Service Licensee P.O. Box 195 Sykesville, MD 21784 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Massive Cerebro Vascular **Physician** week /Medical Due to (or as a consequence of) Examiner 14eer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine signed by the attending physicien and d be detached for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 Yes 2 No 1☐ Yes 20 No within 24 hours aftar death.

To the Funerel Director: After this cartific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other} \( (Specify) \) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) \$ 52035 October 30 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Westminister MD 21157 291 CHACKO Stoner 31. Date filed (Month, Day, Year) 32. Registar's Signature State

DHMH 17 Rev 1/2001

Registrar

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2006 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Barnard Sr. Davton Broten October 2006 12:05a /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Howard 1075 St. Michael Road Mount Airy If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, May 7 9. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday, **Funeral** Days Hours 408-30-2241 83 May 1923 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 10a. State 10b. County Howard 1 ☐ Yes 2 No Md Mount Airy Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or 7 USA 1075 St. Michael Road 21771 Funeral th and Mental Hygiene. 7 Is marked other than "natural", or Items ; traumatic event, the Medical Examiner mu 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 14. Bace - American Indian. 11 Marital Status Black, White, etc. 1 ☐ Yes 21 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐XNo Specify: Specify: white Completed by 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b, Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) printing ink technician printing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Barnard Nora Winkler 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health an Important: If item 27 Is any Injury or other trau once. 1075 St. Michael Rd., Mt. Airv, MD 21771 Paul D. Barnard (son) 20b. Place of Disposition (Name of cemetery, crematory or other place) Sharon Baptist Cem. Date 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 11-4-06 West Friendship, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of FacilityHaight Funeral Home & Chapel Day Haight Stevbert P.O. Box 195 Sykesville, MD 21784 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Qnset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 4000 /Medical Due to (or as a consequence of): **Examiner** Equentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine burial-trar Due to (or as a consequence of): physician as the burial-Physician/Medical attending pl 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4□Pregnant at time of death 5 ☐ Other (specify) been signed by the should be detached 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 1□ Yes 2√No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home Residence 6 ☐ Other (Specify) 30 No 1 ☐ Yes 1 Inpatient 2 ☐ ER/Outpatient 3□ DOA Medical Certification: To After this 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 5 Pending investigation Natural after death. I Director: Af d in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours aft To the Funeral Di completely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

To the Hospital or Attending Physician: The law requires that the death certificate be execute

Division or Vital Records, P.O. Box 68760,

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

State Registrar 29b. Signature and title

30. Name and address of person who co

31. Date filed (Month. Day, Year)

DHMH 17 Rev 1/2001

pleted cause of death (Item 23a) (Type, Print)

32. Register's Signature

2006

**ORIGINAL** 

29c. License number

29d. Date signed (Month, Day, Year)

reorgetown Blod. Eldersburg

#### 06-08149 William Burch

#### Please Type or Print in Black Indelible Ink

State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No. Registrar Date of Death Decedent's Name (First, Middle,Last) Physician/ Month Day October 29, 2006 1026 hrs Medical Examiner William Jesse Burch 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) N/A **Baltimore** University Hospital 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign If Under 1 Year If Under 24Hrs 7. Age (In yrs. last birthday) 5. Social Security Number 6 Sex **Funeral** Country) Months Days Hours Director 01-29-1967 38 Maryland 215-88-3732 1 X M 2 Usual Residence of Decedent 10d Inside City Limits 10c. City, Town or Location 10b, County Yes 2 No Baltimore Marvland N/A death with the Maryland Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21229 3655 Hineline Rd. **USA**  Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black Funeral 12. Was Decedent Ever in U.S. 11 Marital Status White, etc. Armed Forces? 1 Never Married 2 X Married Yes White 0 Yes 2 No specify Specify hours after Divorced Give Year Widowed "natural" þ 16a Decedent's Usual Dccupation (Give kind of work done 16b Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) should be filed within 72 than is marked other than ' itic event, the Medical Window Installation Carpentry Baltimore, MD 21215-0036 nt of Health and Meutal Hygiene

tt. If item 27 is marked other th
other traumatic event, the Medi 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Murrill F. Burch Mary M. Geiler Be 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ၉ 3655 Hineline Rd. Brenda Burch, wife Baltimore. MD. 20a Method of Disposition

1 Burial 2 Cremation 3 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State crematory or other place) West Arundel Crematory 11-01-06 Department o Odenton, MD Donation 5 Other Specify njury or 21. Signature of Funeral Service Licensee 22 Name and Address of Facility al Home, Inc. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each line /Medical Death Complications of gunshot wounds (2) to the abdomen Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions Due to (or as a consequence of) if any, leading to immediate Examiner cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last Fo the Hospital or Attending Physician: The law requires that the death certificate be executed and Physician/Medical AMENDED #23a,27,28a-f,perME,g861,11/14/06 TT X UNPENDED attending physician or use as the burial -Division of Vital Records, P.O. Box 68760, 23d Date of delivery IF FEMALE: If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Day Year Live birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I ð Yes 2 V No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a Was an prior to completion of cause of autopsy performed? death? ✓ Yes 2 26.Place of Death (Check only one) 25 Was case referred to medical Be Other<sub>4</sub> examiner? Hospital: 1 ✓ Inpatient 2 Nursing Home 5 Residence 6 Other ER/Outpatient 3 DOA After this 1 V Yes 2 28a. Date of Injury (Month, Day, Year) 28b Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Manner of Death Certification: Natural 1 Yes 2 X No Pending 2/11/2006 11:30 pm subject was shot by police 2 Accident Investigation 28f. Location (Street and Number of Rural Route Number, or Town, State 3121 Strickland Street Baltimore, MD 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Could not be Suicide determined within 24 hours a To the Funeral 1 4 X Homicide (Specify) dwelling Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number October 30, 2006 O.C.M.E mi 30. Name and addr ss of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) Registrar's Signatar State 0 2 2006 Registrar

			1 - For State Registrar	State of Maryland		artment of tificate of			ene 2006	34797
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	/Medio	cal	Elizabeth  4a. Facility Name (If not institution, give st	P. Bauer		4b. City Town	or Location of Death		30, 2006 4c. County of Death	9:30 A <sub>M</sub>
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	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. Ia	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs.	8. Date of Birth (Month, Day,		place (State or Foreign htry)
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Maryland	nd 2 shi lth and 27 is m traum		19a. Informant's Name/Relationship (Type)  Patricia Bush						City or Town, State, Zip	
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)	10			BMD 25	23a) (Type, P	rint)	ッ	1136	•	
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State of Maryland / Department of Health and Mental Hygiens 006 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Month Year **Physician** BERRETT OCTOBER JUDITH 1407 29 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner COLUMBIA HOWARD GENERAL HUSPITAL HOWARD COUNTY If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Hours 1 □ M 2XXX 65 217-40-6475 Director Maryland Usual Residence of Decedent death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County or Iteme 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2√ No MD Howard Elkridge Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6390 Loudon Avenue 21075 United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 72 hours after 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: XXNever Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes XX No Specify: White δ Specify: 3 Widowed 4 Divorced natural Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Clerk Accounting 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Heelth and Mental Hy Important: If Item 27 is marked oth any light or other traumatic event Quite. 18. Mother's Name (First, Middle, Maiden Sumame) Be Harold Lee Berrett Ethel Louise Mohler 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Larry Warch (Brother-in-law) Mt. Airy, 2670 Walston Road MD 21771 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metro Crematory 4 □ Donation 5 □ Other (Specify) 10/31/06 Catonsville, MD 21. Signature of Funeral Service Licensee Gary L. Kaufman Funeral Home at MMP, Inc. 7250 Washington Blvd. Elkridge, MD 21075 Wans aluch 23a. Part1. Enjoy the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of feart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician SEPTIC SHOCK WEEKS /Medical resulting in death) Due to (or as a consequence of): Examiner PNEUMONIA MONTH Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): The law requires that the death certificate be executed the burial-transit STEMIC LUPUS ERTHEMATOSUS YEARS and resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. the ettending physicien Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? ò Day 4☐Pregnant at time of death 5 Other (specify) detached 9 ☐ Unknown ٥ signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, à should be 1 ☐ Yes 2 ☑ No 3 Probably 4 Unknown Completed peeu 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate hes page 2 autopsy performed? 1 Yes 2 No Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death Check only one Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No ē CertIfication: To 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident filled in by the Director 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury · At home, larm, street, factory, office building, etc. (Specify) 4 \ Homicide within 24 hours after To the Funeral Dire 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier cal ŝ 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D 63242 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NIRAV G. SHAH PATUXENT PARKWAY SVITE 200 COLUMBIA, MARYLAND 21044 10724 LITTLE 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2 2006 Registrar

			1 - For State Registrar	State of M	arylan		artmen rtificat			and M	lental Hy	gien,	CUUI	5	34799	9
			Decedent's Name (First, Middle, L.	ast)							2. Date of De		٧		3. Time of Death	
	Physici /Medi		Jane :	F	Bu	czkows	ki				Octobe	r 30	,2006	ear	5:05p	М
N	Examir		4a. Facility Name (If not institution, g	ive street and number)			4b. City,	Town, or	Location o	of Death	, , , , , , , , , , , , , , , , , , , ,	40	. County of	Death		
			Glen Burnie Hea	lth & Rehab	ilit:	ation	G1e	n Bu	rnie			A	nne A	run	de1	
	Funeral			Sex 7. Ag		last birthday)	If Under	1 Year	If Under	24 Hrs. Min.	8. Date of Bir (Month, Da	rth	9	Birth	lace (State or Forei	ign
	Director		217~18~5903	1 □ M 2 🛣 F	82	Yrs.	Months	Days	Hours		May 7,			Coui	MD	
	P		Usual Residence of Decedent													
	aryla hov	_	10a. State 10b. County			y, Town or Lo								1	Od. Inside City Limit	
	Ba-f	cto	MD Anne Arı	ındel	Gle	n Burn	ie								1 Tyes 2 N	10
	or 2	Dire	10e. Street and Number				10f. Zip						tizen of Wha	t Cou	ntry?	
	within 72 hours after death with the Maryland ene. than "natural", or Items 23s or 28s-1 show ha Madigal Examinar must be notitled at	by Funeral Director	421 6th Avenue 1					060				U.S				
	eb in de	nue	11. Marital Status	12. Was Decedent Armed Forces?	•	.S. 13.	Was Deced If Yes, spec	dent of Hi cify Cuba	spanic Orig n, Mexican	gin? (Spe i, Puerto	ecify Yes or No Rican, etc.)	o-	14. Race -			
36	or i	ΥF	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 🕅 If Yes, Give Year or Dates:	No		1 🗆 Yes	2 <b>X</b> No	Specify:				Specify:	Whi	.te	
21215-0036	turai E E	pg p				1.40- 0	da ada 11aa	10				1 10) 11				
15	n 72	Completed	15. Decedent's (Specify only highest g	rade completed)		16a. Dece	kind of wo DO NOT us	al Occupa rk done d	ition Tu <i>ring m</i> ost	t of worki	ing	16b. K	ind of Busin	ess/in	dustry	
12	than than	Щ	Elementary/Secondary (0-12)	College (1-4or	5+)	Beaut			,			Be	auty			
	Hygi Hygi ther mt, 1	ပိ	17. Father's Name (First, Middle, Las	st)		<u> </u>		· · · · · ·	18. Mothe	r's Name	(First, Middle	1				
an	d be antal	Be C	Unknown													
2	mari mati	2	19a. Informant's Name/Relationship	(Type Print)		19b Mailir	na Address	(Street a		-	nia Fra al Route Numb			to Zir	Code	
Maryland	d 2 s th an 17 ie trau		Ms. Patricia Bea		er										and 21128	)
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Madical Examinat must be notified at ance.		20a. Method of Disposition	zu / Duugiii	20b. P	lace of Dispo	sition (Nar	ne of					ocation - Cit			
٥	nt of nt of it it it it it		1 Burial 2 ☐ Cremation 3		C	emetery, crer	natory or o	ther place		ov. <sup>0</sup>			en Bui			
Baltimore,	ritan ritan niun		4 □Donation 5 □ Other (Spec 21. Signature of Furieral Service Lic			en Have										
Ba	Depermination of the permit in		21. Signature of Pulleral Service Lice	Brista	MOI						_				ne, P.A.	
			23a. Part1. Enter the disease, or co	malications that any sa	d the death						Glen Bu		e MD 2	1100		
н			shock, or heart failure. List onl	y one cause on each li	ne.	ii. Do not ent	er trie mod	e or dying	, such as	Cardiac o	птеѕрпатоту а	irreşi,			Approximate Interval Between Onset and Death	
	Physician		Immediate Cause (Final disease or condition resulting in death)	a	3.2	un	ver.	- 1	2	26	NAC	_				
	/Medical Examiner	î	1	Due to (or as	a conseq	uence of):	4		4 - 4	1	- c -	A 0				
Н		_	Sequentially list conditions,	b. Due to (or as	7000000	520V.	1100	ENC	M		JING	24-7.9				
	pe tis	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequ	uence or):										
<i>-</i>	and and I-trar	xan	that initiated events resulting in death) Last	c. Due to (or as	a conseni	neuce of).								-		
8760,	cate be executed obysicien and the burial-transit	E E		220 (0) 22		201100 017.										
87	phys phys s the	dicai		d										+		
9 X	eath certific attending p	Physician/Med	IF FEMALE.	23c. If yes, outcome	of pregna	nev										
Вох	atten for u	ian	23b. Was decedent pregnant in the past 12 months?	1⊟Live birth 4⊟Pregnant a	2 Fetal	Ideath 3 □	Ectopic pr						23d. Date of Month	delive	ery Day Year	
	the dr	ysic	1 □ Yes 2 ☑ No 9 □ Unknown	9□ Unknown	t titrie or u	ealli 5	J Other (sp	ecny)								
P.0	The law requires that the death certific Ite has been signed by the attending p age 2 should be detached for use as:	유	Part II. Other significant conditions	contributing to death b	ut not resi	ulting in the u	nderlyina c	ause give	n in Part I.		23e. Did t	obacco	use contribu	te to th	ne cause of death?	
of Vital Records,	signed be det	d by				•	, ,	3				Yes 2			ably 4 Dunknow	٧Ŋ
Ö	w requir been si should i	Completed														
3ec	has has	пр									24a. Was		24b. Wer	r to co	psy findings availab mpletion of cause of	ile f
a	cate										1 Yes	2 No			2 No	
VII.	ding Physician: The h. After this certificate h. funeral director, page	Be	25. Was case referred to medical examiner?	Hospital:				Otho		/	(Check only o					
of	Phys this al dir	ဥ	1 Yes 2 No	1 🔲 Inpatie		ER/Outpatien			4 DANUI		ne 5 Resi			Specif	r)	
Ľ.	ding F h. After funera	on	27. Manner of Death 1 Matural 5 ☐ Pending	28a. Date of Inju (Month, Da	y Year)	28b. Time of Injury		8c. injury Work			28d. Describe	how inju	ry occurred			
Sic	ittendi death. ctor: A y the fu	cat	2 ☐ Accident investigati 3 ☐ Suicide 6 ☐ Could not	he			М		res 2 □ N							
Division	I or Attend after death Director: I in by the	Certification:	4 Homicide determine	28e. Place of Inj building, et	ury - At ho c. (Specify	ome, farm, str v)	eet, factory	, office		4	City or To			or Rura	I Route Number,	
_	pital purs a erai l	ပို	29a. Certifier 1 Certifying F	hydidae. To the hear	nt m: !	ulades desi		na ab	a d-4-	d =1= -						
	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the fune	edical	(Check only 2 Medical Exe	Physicien: To the best eminer: On the basis o and manner st	f examina	wieuge, death tion and/or inv	occurred vestigation,	at the tim , in my op	e, date and inion, deat	u piace, a th occurre	and due to the ed at the time,	date and	and manne i place, and	or as si due to	ated. the cause(s)	
	thin the	Med	29b. Signature and title of certifier	and mariner st	atou.		290	. License	number			29d Da	te signed (M	fonth.	Day Year)	_
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7	40			The state of the s				11	35	00		10	-31-	U	0	
	10		30. Name and address of person who	completed cause of d	leath (Item	1 23a) (Type,	Print)	7	Ani	N / A	Dal	. 1	17-0-1	`	21227	
			31. Date filed (Month, Day, Year)	32. Ragistr	JEG ar's Sinna		24/	-( /	4 / 1/	VIT	rous	1	N ITV	, .	111/	
	Sta Registr		SIOU A O		5 Sigila	80 B	nace I	,								

06-07913 Eddie Boyd Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

idle Boyd		1- For State Certificate of Death Registrar	Reg No 2006	34801
Physicia	an/	1. Decedent's Name (First, Middle, Last) Eddie Boyd	Month Day Year	3. Time of Death 1920 hrs
ledical Exami		Edward Lee Boyd  4a Facility Name (if not institution, give street and number)  4b City, Town, or Location of	October 21, 2006  f Death 4c. County of Death	
		Johns Hopkins Hospital Baltimore		
Funeral Director		5. Social Security Number 248-90-2362 6. Sex 17. Age (In yrs. last birthday) 17. Age (In yrs. last birthday) 18. Age (In yrs. last birthday) 19. Age (In yrs.	Foreign	
any	}	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location		10d Inside City Limits
ž .	٦	MD Baltimore City		1 X Yes 2 No
ne Maryland or 28a-f show fred at once.	Director	10e. Street and Number 10f. Zip Code 21239	10g Citizen of What Coun	try?
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland tent of Heath and Mornal Hygiens and the Heath and Mornal Hygien and mit. If item 21's is marked other than "natural", or items 23a or 28a-f she mit. If item 21's is marked other than "natural", or items 23a or 28a-f she in the Iraumatic event, the Medical Examiner must he notified at once	Funeral	11. Marital Status  12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Original Status 14. Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican,	in? ( Specify Yes or No- 14 Race - Americ	an Indian, Black,
fter dez I", or i		1 Yes 2 X No 3 Widowed 4 Divorced It Yes, Give Year 1 Yes 2 X No specify:	Specify Black	
hours a 'natura	ed by	15 Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give k during most of working life. DO NOT usual control of working life. DO NOT usual control of working life.	ind of work done 16b Kind of Business/Ir	ndustry
336 thin 72 l ne • than "1	₩.I	Elementary/Secondary (0-12) College (1-4 or 5+)  12th n/a janitorial	21000100 200	
5-0036 lled within 7 Hygiene I other than the Medica	Comple	17. Father's Name (First, Middle, Last)  18. Mother's	<u> </u>	/A Co.
ID 21215-003 should be filed within and Mental Hygiene 7.7 is marked other the natic event, the Med	o Be	Charlie Boyd	Fstelle Davis ber or Rural Route Number, City or Town, State,	Zin Code)
and 2 should tealth and Me tem 27 is ma traumatic ev	ř		Baltimore, MD 21239	2,5 0000/
ore, M s 1 and 2 of Health If item 2		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery,	Date 20c. Location - City or	Fown, State
Pages nent of ant: I		4 Donation 5 Other Specify Mt. Zion Cemetery	11/03/2006 Baltimore Ma	arvland
Baltimore, permit Pages I at Department of Hec Important: If ite injury or other tr		21. Signature of Funeral Service Licensee 22. Name and Address of Facility	Wylie Funeral Home, P.	Α.
Physician	-	23a Part I. Enter the disease, or cort lications that caused the death. Do not enter the mode of dying, such as ca	et: Baltimore, MD 21217 ardiac or respiratory arrest, shock, or heart	Approximate Interval Between Onset and
/Medical		failure. List only one cause on each line Immediate Cause (Final disease a Narcotic intoxication		Death
Adminier		or condition resulting in death)  Due to (or as a consequence of):		
	iner	Sequentially list conditions, if any, leading to immediate cause Enter Underlying Cause		
ted 1 ansit	Examiner	(Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):		
760, cate be executed physician and he burial - transit	Medical	X UNPENDED #1.23a.27.28a-f. perMF. C861. 11/3	20 /06 TT	
8760, inficate being physic as the bur		IF FEMALE: 23c. If yes, outcome of pregnancy	23d. Date of delivery	ay Year
ion of Vital Records, P.O. Box 68760, trending Physician: The law requires that the death certificate be executed teath for After this certificate has been signed by the attending physician and informated director, page 2 should be detached for use as the burial - transi	Physician	past 12 months?  4 Pregnant at time of death 5 Other (Specify) 9 Unknown		
ires that the c signed by the	þ		ırt I 23e Did tobacco use contribute to t  1  Yes 2 ✓ No 3 Prob	
ords,  * requir  s been s should	ompleted		autopsy prior to c	copsy findings available ompletion of cause of
Recol The law icate has	uo:		performed? death?  1 Yes 2 ✓ No 1 Ye	s 2 No
Vital Rec ysician: The his certificate director, page	Be C	avaminar? Othor:	(Check only one)  Nursing Home 5 Residence 6 Other	
n of Vi ding Physi After this funeral dii	P.	1 V Yes 2 No  27 Manner of Death  28a Date of Injury  28b Time of Injury  28c Injury at Work		
ion ( tending eath tor: Al	cation:	1 Natural 5 Pending (Month, Day Year) 2 Accident Investigation Pending Investigation Print 10/21/2006 unknown 1 Yes 2 X	No unknown	
<u>∞</u> ₹ ; 3 €	ertifica	3 Suicide 6 X Could not be determined (Specify) House	c. 28f Location (Street and Number or Ru or Town, State) 1516 N. Poi Baltimore, MD	ral Route Number, City nt Street
ospi hou iner y fill	0	29a Certifier	ace, and due to the cause(s) and manner as start	ed
To the Ho within 24 b To the Fu	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death ocan and manner stated  29b. Signature and title of certifier  29c. License number	curred at the time, date and place, and due to the	
	2	Months of Market College Co.C.M.E.	October 22, 2006	
		30. Name and address of person who completed cause of death (Item 23a)	MD 24204	
		Margarita Korell MD. Assistant Medical Examiner 111 Penn Street, Baltimore 31. Date filed (Month, Day, Year) 32. Jegistrar's Signature	e, MD 21201	
Pegis	state	AIAU A B 2005   AM - A AGAME!		

06-08170 Stephen Carbary

# Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

tephen dalbary	F	I- For State Registrar	Certificate				Reg No. 20	06 3480
Physicia Medical Examir	n/	1 Decedent's Name (First, Middle, Last) Stephen Rea Carbary				2. Date of De Month October	Day Year	3. Time of Death 1223 hrs
		4a. Facility Name (if not institution, give street and number)		4b. City, Town,			4c. County o	
		St. Agnes Hospital  5. Social Security Number 6. Sex 7. Age (	In yrs. last birthda	Baltimore y) If Under 1 Y		r 24Hrs. 8. Date of B	1	N/A  9. Birthplace (State or Foreign
Funeral Director		213-60-6154 X M 2 F	53		ays Hours		15, 1953	Maryland
any	- 1	Usual Residence of Decedent           10a State         10b. County         10	Oc. City, Town or L					10d Inside City Limits
Maryland 28a-f show any d at ouce.	اة	MD Baltimore		Catonsvil	.le			1 Yes 2 XNo
oith the Maryland 5.23a or 28a-f shov notified at once.	Director	10e. Street and Number		10f. Zip Code			10g. Citizen of Wh	
vith the s 23a o		410 Roanoke Drive  11. Marital Status 12. Was Decedent E	ver in U.S. 13		.228 Hispanic Orig	in? ( Specify Yes or N	United S	- American Indian, Black,
death v	Funeral		No			Puerto Rican, etc.)	White	
s after rral", o	ᇗ	Widowed 4 Divorced If Yes, Give Year or Dates:  15. Decedent's Education (Specify only highest grade complete.		Yes 2 X I		and of work done	Specify:	White
2 hour	eted	Elementary/Secondary (0-12) College (1-4 or 5+	duri	ng most of working I			TOD TAING OF BUIL	SITIOSS/ITIOGSGY
15-0036 filed within 72 Hygiene d other than " the Medical.	Completed	12		Mason				ruction
21215-0036  Mental Hygiene marked other than "natural", or items 23a or 28a-f 3he c event, the Medical Examiner must be notified at ouce	Be Co	17. Father's Name (First, Middle, Last)  Donald Carbary			1	s Name (First, Middle etty Towns		
e na de la	일	19a Informant's Name/Relationship (Type, Print )			reet and Num	ber or Rural Route No	umber, City or Towr	
MD and 2 she alth and 2 is m 27 is raumat	1	Diane Stevens - Sister  20a Method of Disposition		Roanoke Isposition (Name of	<u>_</u>	- Catonsv		21228 City or Town, State
Baltimore, MD 2 sernit. Pages I and 2 shou Oepartment of Health and I important: If item 27 is r injury or other traumatic		1 Burial 2 X Cremation 3 Removal from State	West A	or other place)	•	11-3-2006		
Baltimore permit. Pages I Department of E Important: If injury or other	1	4 Donation 5 Other Specify 21. Significant of Funeral Service Linens	<del> </del>	ematory 2. Name an Addr	and of English			
		23a. Part I. Enter the disease, or complications that caused the				Ambrose F		
Physician /Medical		failure. List only one cause on each line.			ig, such as ca	ardiac or respiratory a	irest, silock, of flee	Between Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death)  a. Intracerebra  Due to (or as a consequence)	uence of):					
Same of the same o	<u>.</u>	Sequentially list conditions, if any, leading to immediate  b Hypertension  Due to (or as a consequence)		ne use				
	Examiner	cause Enter Underlying Cause (Disease or injury that initiated						
ecuted and transit		events resulting in death) Last Due to (or as a conseq d d	derice or,					
al al a	Medical	■ AMENDED #23	-b.27 per	ME, 2861, 11	/17/06 5	T		
8760, iificate be ng physici		IF FEMALE: 23b. Was decedent pregnant in the				pregnancy	23d. Date of Month	delivery Day Year
Box 687 death certifit the attending ed for use as t	sician	past 12 months?  4 Pregnant at till 1 Yes 2 No 9 Unknown		Other (Specify)				
D. B. t the de by the	된	Part II. Other significant conditions contributing to death I	but not resulting in	the underlying caus	se given in Pa	nt I 23e Did	tobacco use contri	bute to the cause of death?
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the ras after death.  "I Director: After this certificate has been signed by led in by the funeral director, page 2 should be deach.	d by					1 Y	es 2 No 3	Probably 4 🗸 Unknown
ords, P w requires t as been sign	Completed						opsy p	Vere autopsy findings available rior to completion of cause of eath?
tal Rec rian: The la certificate h ector, page	S			00.5		1 Yes	2 No 1	Yes 2 No
Vital Reo ssician: The his certificate director, page	æ	25. Was case referred to medical examiner?  1 ✓ Yes 2 No  Hospital: 1 ✓ Inpatient	t 2 ER/Outpa	atient 3 DOA	Other:	(Check only one)  Nursing Home 5	Residence 6	Other:
ing Phy After th	n: To	27. Manner of Death 28a. Date of Injury	/ 28b. Tim		njury at Work		e how injury occurre	ed
ivision or Attendi after death. Director:	catio	1 X Natural 5 Pending 2 Accident Investigation	At home form		Yes 2		(Street and Number	er or Rural Route Number, City
Division pital or Attent ours after death neral Director: filled in by the	Certification:	3 Suicide 6 Could not be determined (Specify)	ry - At Home, fami	, street, factory, offic	e building, et	or Town,		of Rula Route Number, Ony
Division of Vital Records, P.O. Box 68. To the Hospital or Attending Physician: The law requires that the death certifi within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	ledical C	29a. Certifier 1 Certifying Physician: To the best of my						
To th withi To th	Medi	one)  2 Medical Examiner: On the basis of exam and manner stated.  29b. Signature and title of certifier			ense number			ed (Month, Day, Year)
		Jashe Most M.	P	О.	C.M.E.		October 31	, 2006
		30. Name and address of person who completed cause of de		111 Dec - Ct	A Deltine -	ro MD 24204	1	· · · · · · · · · · · · · · · · · · ·
	o ta	Tasha Greenberg MD. Assistant Medical  31. Date filed (Month, Day, Year)  32. Restarts	Signature 💆	111 Penn Stree	et, Baitimo	1e, NID 21201		
Regis	ate	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	والتخافر المساوء	1				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Year October 1:30 P M Betty Jean Cason /Medical 2006 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Hospital Baltimore If Under 1 Year | If Under 24 Hrs.

Months | Davs | Hours | Min. 5. Social Security Number Age (In yrs. last birthday) **Funeral** 6. Sex Birthplace (State or Foreign Country) 1 M 2 F 75 Director 215-24-7893 Usual Residence of Decedent 11/29/1930 Knoxville, TN with the Maryland 10a. State 10c. City, Town or Location r 28a-f show notified at 10b. County 10d. Inside City Limits 1 XIYes 2 □ No Directo MD n/a Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or e r than "natural" or items 23a the Medical Examiner must b 4048 Wright Avenue 21205 by Funeral USA ould be filed within 72 hours after death Mental Hygiene. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ② No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🗷 No Specify 3 ☐ Widowed 4 Noivorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Salesperson Retail 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Eugene Larmer Davis Mae Elizabeth Shoffner 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2:9 Department of Health at Imprortant: If Item 27 is any Injury or other trauonts. Betty Joyce Cason/Daughter 4048 Wright Avenue, Baltimore, MD 21205 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Parkwood Cemetery 11/4/06 Baltimore, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Carry L. Kaufman Funeral Home @ MMP, Inc. vans 7250 Washington Blvd., Elkridge, MD 21075 23a. Part1. Enley he disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or Heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Sepsis /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Decase or nury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): attending physician and for use as the burial-tran Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 1 ☐ Yes 2 No 3 ☐ Ectopic pregnancy Month Year Day 5 ☐ Other (specify) 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Kloppins abete 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed Hyportensia 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient ٩ 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined

Records, P.O. Box 68760. Division or Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certified

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State Registrar

4 Homicide

(Check only

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

M.D. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

DHMH 17 Rev 1/2001

**ORIGINAL** 

Sinal

1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

			1 - For Amend #	State of Ma 10c-f ,17&1	aryland / 8 PER	Depa AMA Cer	rtment of I	Health a Death	and Mei 706 JI	ntal Hygie	200	6 3	4803
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п	Physici: /Medic		Pauline K. Donr	ell						tober 2	7, 200	6	6:25 PM M
	Examin	er	4a. Facility Name (If not institution, g	ive street and number)			4b. City, Town,		of Death		4c. County of	f Death	
			National Luther  5. Social Security Number 6		e (In yrs. last	hirthday	Rockvi		24 Hrs a	Date of Birth	Montg		e (State or Foreign
	Funeral Director		209-24-5952	1□M 27 F	7.5	Yrs.	Months Days		Min.	(Month, Day, Ye	ar)	Country)	lvania
			Usual Residence of Decedent		, ,					0, 19	J1 1	eimsy	Ivalita
	how	_	10a. State 10b. County		10c. City, To	own or Loc	ation						Inside City Limits
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	vith th	Director	10e. Street and Number 9305A		lace		10f. Zip Code	904 2	0850	10g.	Citizen of Wh		?
	should be filed within 72 hours after death with the Maryland of Mental Hygiene. marked other than "naturel" or Itams 23a or 28a-f show marked other than "naturel" or Itams 23a or 28a-f show mailc event, the Medical Examinal must be notified at	Funeral	13117 Clifton R	12. Was Decedent	Ever in I.I.S.	13 W	/as Decedent of	70-1		y Yes or No-	_	- American	Indian
	ritan Iner	F	1 Never Married 2 XMarried	Armed Forces? I □ Yes 2X1		l If	Yes, specify Cub	oan, Mexicar	n, Puerto Ric	an, etc.)		, White, etc.	
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<u> </u>	and Men Is marke	ပ	19a. Informant's Name/Relationship		1	9b. Mailin	g Address (Stree	1		oute Number, Ci	ty or Town, S	tate, Zip Co	ode)
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altimore,	s 1 a		20a. Method of Disposition		20b. Place	of Dispos	sition (Name of atory or other pla	-	Date		. Location - C		
Ē	Pages nent of ant: If it		1 ☐ Burial 2 ☐ Cremation 3 14 ☑ Donation 5 ☐ Other (Spe			•		.					
Balt	permit. Pages Department of Important: If it any injury or o		21. Signa in or Funeral Stryice Lic Rona d S	Wade hire	ector	St	Name and Addr ate Anat 1timore,	comy B	oard 6 21201	55 W. Ba	altimo:	re Stı	reet
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	Physician -	, ,	shock or heart failure / List or			11	11.						nset and Death
	/Medical		disease or condition resulting in death)		a consequent		lder	conc	-			/	minth
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687	ficate physics the	edicai		d									
XO	The law requires that the death certifi tie has been signed by the attending is age 2 should be detached for use as	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome			Catania avanana				23d. Date	of delivery	
Division of Vital Records, P.O. Box	death	icia	in the past 12 months? 1 □ Yes 2 □ No	1 □ Live birth 4 □ Pregnant a 9 □ Unknown			Ectopic pregnand Other (specify) _				Mont	h Da	y Year
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s,	res tha igned be det		Part II. Other significant conditions	contributing to death b	out not resultin	g in the un	derlying cause g	iv <i>e</i> n in Part I	l.	23e. Did tobace			y 4 □Unknown
ord	w require been si should b	eted								1 195	2,23110 3	Frobably	y 4 Donkhown
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<u></u>	ician: The I certiticate ha rector, page									1 Yes 2 □		Yes 2	No
Ž	Physician: this certitic al director,	) Be	25. Was case referred to medical examiner?	Hospital:		(0	07 BOA   Ot	hor		heck only one)	4 500		
ot	Attending Physician: or death. ector: After this certities by the funeral director.	. To	1 ☐ Yes 2 ☐ No 27. Manner of Death	28a. Date of Inju	ury 28	b. Time of	28c. Inju	ıry at		5 Residence			
lo	nding th: :: Afte	atior	1 Natural 5 Pending 2 Accident investigat	(Month, Da	iy Year)	Injury		ork? ]Yes 2. ☐	No				
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	tal or	Certification;	Tiomida	building, et	ic. (Opcony)								
	To the Hospital or At within 24 hours after of To the Funeral Direct completely tilled in by	edical	29a. Certifier 1 Certifying (Check only one) 1 Medical Ex	Physician: To the best aminer: On the basis o and manner st	of examination	dge, death and/or inv	occurred at the t estigation, in my	ime, date ar opinion, dea	nd place, and ath occurred	due to the cause at the time, date	e(s) and mani and place, an	ner as state nd due to the	ed. e cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier	1.0				ise number	,	29d.	Date signed	(Month, Day	v, Year)
i			1 Suls	mally	Mp		0005	0612		00	Lober	28.	2006
			30. Name and address of person wh			a) (Typ <i>e</i> , F	Print)	_	/				
			SAMUZ-	G. MALL	Gn Mu	)	7701 VC	ire D	rive R	ockville	MD 2	08-50	
	Sta Registr		30. Name and address of person with SAm UZ = 31. Date filed (Month, Day, Year)  NOV 0 2 2	006 Hegistr	rar s signature	Sign	all I						

		1	- State Amend item#9,15,16	State of Maryland Sa-b,17,18,19a-b	d / Depar , <sup>20a</sup> Ce/t	tment of Health	and Mental Hy 1/16/06 TT	giene 006	34804
	Physicia	an	Decedent's Name (First, Middle, Last)	DAVIS			2. Date of D Month		3. Time of Death
	/Medic Examin		As Facility Name (If not institution, give str	reet and number)	A	4b. City Town, or Location	-I MORE	4c. County of Dea	
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_	aryland show del		Usuel Residence of Decedent  10a. State 10b. County	10c. City	, Town or Loca			-	10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	r 28a-f	Funeral Director	MD  10e. Street and Number		Baltim	ore 10f. Zip Code		10g. Citizen of What Co	Λ
	e 23a o	eral D	1217 W. Fayette S	treet  2. Was Decedent Ever in U.	S 13 W	21223	Origin? (Specify Yes or N	USA 0- 14. Race - Ame	erican Indian.
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Maryland 21215-0036	コピトド	(a 1	19a. Informant's Name/Relationship (Type Domina Jackson	e, Print)	428 E.	Address (Street and Nur 22nd Street, A	pt. B, Baltimor	ber, CMO 21218 ate,	Zip Code)
ore, l	permit. Pages 1 and 2 should Deportment of Heelth and Men Important: If Item 27 Is marke any njury or other traumatic 9066.		20a. Method of Disposition  1 ☐ Burial 2 <b>X</b> Cremation 3 ☐ Re	moval from State	lace of Dispos emetery, crem	ition (Name of atory or other place)	Date	20c. Location - City or	Town, State
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	φ ±	lner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseq	uence ol):	HUCKET I	VI MICI C		0 001112
oʻ	cale be executed physician and the burial-transit	Examiner	that initiated events c. resulting in death) Last	Due to (or as a conseq	uence ol):				
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.O. Box (	he death certificate be executed the attending physician and ched for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Winknown	ic. If yes, outcome of pregna 1 Live birth 2 Feta 4 Pregnant at time of d 9 Unknown	il death 3 □	Ectopic pregnancy Other (specify)		23d. Date of de Month	elivery Day Year
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f Vita	Physician: Th this certificete ral director, pag	To Be	25. Was case referred to medical examiner?  1 □ Yes 2 □ No	ospital:	ER/Outpatient	Other	lace of Death (Check only ] Nursing Home 5 🗆 Re		ecify)
	e in		27. Manne Cheath  1 Platural 5 Pending 2 Accident Investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work? M 1 \( \t \) Yes 2		e how injury occurred	
Division	To the Hospital or Attending within 24 hours after death To the Funeral Director: After completely filled in by the fune	Certification:	2 Accident 3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Special	ome, larm, stre fy)	et, lactory, office		(Street and Number or Fown, State)	lural Route Number,
	Hospits 24 hours Funera	Medical (	29a. Certifier 1 Certifying Phys (Check only one)	ician: To the best of my known are: On the basis of examination and manner stated.	owledge, death ation and/or inv	occurred at the time, date estigation, in my opinion,	e and place, and due to the death occurred at the time	e cause(s) and manner a e, date and place, and du	s stated. e to the cause(s)
	To the within To the comple	Me	29b. Signature and title of certifier	) 0.0.		29c. License numb	per 162	29d. Date signed (Mon	th, Day, Year)
			30. Name and address of person who co	poleted cause of death (Iter	m 23a) (Type, j	Print)	100	10/25,	1200
	C4	ate	1. Neal Roynold 31. Date filed (Month, Day, Year)	S BON Sen 32: Registrar's Sign	2015	toptal;	2000 We	34 BALTIW	topto grol
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			For State		State of	Marylar		partmei ertifica				ental Hy	ygienę Rog. NG	711116	5	34805
			Registrar  1. Decedent's Name (First, I	Middle, Last)	)			-,	.5 0, 1			2. Date of D	eath	•		3. Time of Death
	Physici		Diane Dunnocl									Month //	20ay	y Yea	ar l	2:54PM
	/Medic Examin		4a. Facility Name (If not insti		street and numb	per)		4b. City	, Town, o	r Location	of Death	10	4c.	County of D		<u> </u>
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	pu k		Usual Residence of Decede  10a. State 10b. Co			10c. C	ity, Town or	Location							100	d. Inside City Limits
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$\overline{\mathbb{D}}$	death	era	11. Marital Status		12. Was Deced	ent Ever in t	J.S. 1	3. Was Deci	dent of H	lispanic C	rigin? (Spec	cify Yes or N	10-	14. Race - A		
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<u>a</u>	id be ental ked c	To B	Ja	mes Gre	een							Betty	Lewis			
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2,≥	1 and 2 Heelth e tem 27 le		Shawan Dunno	ck / Da	aughter		_ 3	Shargo	Court	t; Bal	timore	, MD 2	1220			
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<u></u>	Physic this ce al dire	10	examiner? 1 ☐ Yes 2 ☑ No	ŀ	Hospital: 1 🔀 Inj	patient 2	] ER/Outpa	tient 3 🗆 🗅	OA		Nursing Hom	ne 5∐Re	sidence	6 □Other (S	Specify)	
2	ding Ph h. After th funeral	ü	27. Manner of Death 1 ☑Natural 5 ☐ F	ending	28a. Date of (Month)	Injury Day Year)	28b. Tim Inju	У	28c. Injur Wor			8d. Describe	how inju	ry occurred		
sio	ttendi deeth. ctor: A y the fu	catl	2 ☐ Accident in	ould not be				М		]Yes 2[			(7)			
jvi	or At efter d Direct in by	ertif	4 Homicide	letermined	28e. Place of building	f Injury - At I g, etc. (Spec		street, facto	ry, office		2	City or T	(Street an own, State	id Number of e)	r Hural .	Route Number,
_	To the Hospitel or Attendi within 24 hours efter deeth. To the Funeral Director: A completely filled in by the fu	Medical Certification:	29a. Certifier 1 (Check only one)	rtifying Phy dical Exami	rsician: To the biner: On the bas and manne	is of examin	nowledge, deation and/o	eath occurre r investigation	d at the tir n, in my c	me, date a	and place, a eath occurre	nd due to the	e cause(s e, date and	) and manner d place, and (	r as sta due to t	led. he cause(s)
_	ro the	Me	29b. Signature and title of c	ertifier				2	c. Licens	se numbe	r		29d. Da	te signed (Me	onth, D	ey, Year)
	-> - O		6/11	0	MI	1704	9	IDNO	2, R	400	000		10	2/29	101	0
	^		30. Name and address of pe	erson who co	ompleted cause	of death (Ite	m a) (Ty	pe, Print)	4				10	101	104	
	.X		DR. Carl M	riddle.	ton a	000	FRa	nKlin	50	de	. Ba	Him	ORE	MD	2	237
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	Regist	rar	1901	VAL	33	Contract of the said	00	1								

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra 34806 Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** DOROTHY REGINA EIDMAN OCTOBER 28, 2006 11:30A.M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner MORNINGSIDE HOUSE OF SATYR HILL PARKVILLE BALTIMORE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year 11/7/1917 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5 Social Security Number **Funeral** Months Davs Min Hours 1 M 2 KF Yrs 88 MARYLAND 212-03-3011 Director Usual Residence of Decedent with the Manyland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County worde the Medical Expulper count be notified at 1 Yes 2 No BALTIMORE GLEN ARM by Funeral Director MD or 28a-f 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number tете 23a 4 GUNPOWDER ROAD 21057 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Never Married 2 ☐ Married 5 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: WHITE 3 X Widowed 4 ☐ Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Il Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 12TH GRADE es 1 and 2 should be filed vor Health and Mental Hygie of Hem 27 is marked other to ther traumatic event, III. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) HAZEL WOOLDRIDGE HOWARD PRICE 0 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) MARTY WILGIS/DAUGHTER 4 GUNPOWDER ROAD GLEN ARM, MD 21057 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Pages 1 ō = 5 permit. Page Department of Important: If any injury or once. 4 □ Donation 5 □ Other (Specify) 11/1/2006 FOREST RIDGE CEMETERY FORESTON. MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. Thes Colara 8521 LOCH RAVEN BLVD. TOWSON, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Alzeheimer's **Physician** year) distase disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leaving to introduct cause. Enter Underlying Cause (Disease or injury Dualto (or as a consequence of) Examiner physician and s the burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) P.O. Box 68760. Completed by Physician/Medical attending for use as 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 4 Pregnant at time of death signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an gothyrucel is autopsy performed? page certificate 2 1 No 1 ☐ Yes Division of Vital or Attending Physician: 25. Was case referred to medical examiner? Be Atter this certition 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Nother (Specify) 125313 Fed /105 Hospital: 1 ☐ Yes 2 X No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A completely tilled in by the ft 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide the Hospitel 102'Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Wind Klux D 31295 10/3/16 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Back Wand Klotsz >
31. Date filed (Month, Day, Year) Kloesz ng 6701 N. CHOLUS SA Sut 4204 32. Agistrar's Signature State Sperks NOV 02 Registrar

		1 - State Amend #20a-c,22, perFh, G861,1	1,0,00 110	ertificate of D	eairi		Reg. No.		3480
Dhygiai	20	Decedent's Name (First, Middle, Last)				2. Date of De Month	ath Day	Year	3. Time of Death
Physici /Medio		RONALD G	SEORGE	FORD SR.		Octobe:	r 23,20	006	9:30 p
Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Lo			4c. County		
		4105 Rhondo Court		Baltimo				N/A	
Funeral Director		186 M 2□ F	68 (In yrs. last birthda 68		If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da Dec. 27	y, Year)	Count	ace (State or Fore ry) y land
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E 9	Funeral	11. Marital Status 12. Was Decedent 8	Ever in U.S. 13	3. Was Decedent of Hisp If Yes, specify Cuban,		ecify Yes or No		ce - America	
ital Hygiene. id other then "natural", or Iteme 23a or 28a-f ehow event, the Medical Examiner must be notified at	þ	Armed Forces?  1 Never Married 2 Married  1 Yes 2 N If Yes, Give Year or Dates:			Specify:	Hican, etc.)		ck, White, e y: Whi	
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7 is n	l	19a. Informant's Name/Relationship (Type, Print)	1	ailing Address (Street and					Code)
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2200		my/ll	I	Baltimore, N			yn, MD 21		
		23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each lin	the death. Do not e	enter the mode of dying,	such as cardiac o	or respiratory a	rrest,		Approximate
iysician			Secretary Comments			/	~1 ~-		
	1	Immediate Cabse (Final disease or condition	FEN	140CAK	DIAL	- /N/	ARC	7	
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/Medic Examin		4a. Facility Name (If not institution Carroll Hos	n, give street and num	nber)		4b. City, T		Location o			4c.	County of C	Death	
Funeral Director		5. Social Security Number 220-26-0186	6. Sex 1∭2 M 2☐ F	7. Age (In yrs. 78	last birthday) Yrs.	If Under 1 Months	1 Year Days	If Under 2 Hours	Min.	8. Date of Bir (Month, Da	th av. Year)	28 N	Countr	ce (State or Fo. y) 1 Carol:
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Department of Health and Mental Hygiene. Important: If tiem 27 is marked other than "natural", any injury or other traumatic event. I'm Medical Expones.		19a. Informant's Name/Relations  Linda Nosle  20a. Mathod of Disposition  f Burial 2 Cremation  4 Donation 5 Other (S.	y - Niece 3 □Removal from S	State New		5 Wate	erta e of her place	nk Ro	d., M	Route Numb lanches ate ,2006	ter.	Md	2110 y or Tow	m, State
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 34809 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Year **Physician** 02: 00 AM October KATHRYN GREEN 31 2000 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Baltimore houspita If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. 11/05/1959 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🙀 F 055-50-1746 46 NY Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits or Iteme 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 Tes 2 No Funeral Director CARROLL MD **ELDERSBURG** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1083 MONTCLARE DRIVE 21784 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 ☐ Yes 2 M No If Yes, Give X Year or Dates: 1 ☐ Never Married 2 ☑ Married 1 Yes 2 No WHITE Specify Be Completed by 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) INTERIOR DESIGNER INTERIOR DESIGN 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be if Health and Mental Item 27 is marked o SABATO SIMONETTI BARBARA KRAUT ဂ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BRIAN GREEN / HUSBAND 1083 MONTCLARE DRIVE - ELDERSBURG, MD 21784 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation
4 Donation 5 Other (S Department of Important: If It eny injury or o 0 3 Removal from State BETH SHALOM 11/01/2006 TAYLORSVILLE, MD 5 Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Part 1. Enter the disease, or complicators that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician zear disease or condition resulting in death) Epithelial Sarcama /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, I ary, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dire to (or as a consequence of): Be Completed by Physician/Medical Examiner or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 Other (specify) 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Inknown 24a. Was an 24b. Were autopsy lindings available prior to completion of cause of death? has 2 \ No 1 Yes 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification; To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 Natural 5 Pending efter death.

Director: Af 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28l. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours e To the Funerel ( 11 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) RES 000 October 2006 31 ankarani 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore, 2401 Bullinger Sinai Hospical W. Belvedere 31. Date filed (Month, Day 32. Registrar's Signature State 0 Registrar

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

100	45.5		1 - For State Registrar	State of Ma	aryland / Dep <i>Ce</i>		it of Hea e of De		R	eg. No:	006	34810
4.	Physici		1. Decedent's Name <i>(First, Middle, La</i> Linda Hale	sı) Hutchinson					2. Date of Deat Month October	Day 25	2006	3. Time of Death 2:56pm M
	/Medic Examin		4a. Facility Name (If not institution, given Carroll Hospita				Town, or Loc	cation of Death Cer	1		ounty of Death arroll	
	Funeral Director				63 e (In yrs. last birthday,	Months		Under 24 Hrs. lours Min.	8. Date of Birth (Month, Day, Nov 8 I	Year) 942	9. Births	place (State or Foreign ntry)
200	f show	or	Usual Residence of Decedent  10a. State 10b. County Carroll		10c. City, Town or L Sykesvill							10d. Inside City Limits 1 ☐ Yes 2 ☐ No
dist	23a or 28a-	I Direct	10e. Street and Number 5819 Victor Dr	ive		10f. Zij 217	Code '84		1	0g. Citizer	n of What Cou	ntry?
5-0036	A Hauth and Mantal Hygiene.  If Health and Mantal Hygiene.  Other traumatic event, the Madical Examiner must be notified at	by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 Nover Married 4 Divorced	12. Was Decedent I Armed Forces?  1  Yes 2 Yes, Give Year or Dates:	Ever in U.S. 13.		dent of Hispa cify Cuban, N 2 XNo S		pecify Yes or No- p Rican, etc.)		Race - Americ Black, White, becify: Wh	
Maryland 21215-0036	Department of Health and Mental Hygiene Important: If Item 27 is marked other then "natural", or Iteme eny Injury or other traumatic event, the Madical Examination one.	Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0·12)	ducation ade completed) College (1-4or 5		dent's Usu e kind of wo DO NOT u		n ng most of wor	king		of Business/in	dustry
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Mary	alth and M		19a. Informant's Name/Relationship Mrs. Anne Howes (						ral Route Number ille, MD			Code)
Baltimore,	nent of Her int: If Item iry or othe	Company of the Company	20a. Method of Disposition  1  Burial 2  Cremation 3  4  Donation 5  Other (Speci		20b. Place of Dispr cemetery, cre Lake Vie	matory or o	other place)	10-3			tion - City or To ${ m vil}1e$ ,	
Balti	Departn Imports eny Inju		21. Signature of Funeral Service Lice	Hau Ch	_ P	.O. E	3ox 195	Sykes		MD 21		Chape1
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Division Division	within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Certification:	2 Accident 3 Suicide 4 Homicide investigation 6 Could not to determined	e 29a Place of Inju	ury - At home, farm, st c. (Specify)	m reet, factor		2 No	28f. Location (St. City or Town		lumber or Rura	al Route Number,
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	20		30. Name and address of person who			Print) RID	GE	RD	WESTA	l INS	TORN	1021157
	Sta	te	31. Date filed (Month, Day Year)	32. Regiona	ar's Signature	Anas	40					

	1 - For State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 005								
Physician	Decedent's Name (First, Middle, Last)	TOP HOTMEC			ate of Death	ay Year	3. Time of Death		
/Medical Examiner	REGINA BERN  4a. Facility Name (If not institution, give st.		4b. City, Town, or L	ocation of Death	<u> </u>	2 006 c. County of Death N/A			
Funeral Director	5. Social Security Number 6. Sex	7. Age (In yrs. last		Hours Min. (M	ite of Birth lonth, Day, Year	r) 9. Birth	place <i>(State or Forei</i> intry) YLAND		
ahow ed at	Usual Residence of Decedent  10a. State  10b. County	10c. City, T	own or Location				10d. Inside City Lim		
with the Mar	MARYLAND N/A  10e. Street and Number		BALTIMORE  10f. Zip Code		10g. C	itizen of What Cou	intry?		
e 23a	1214 KEVIN ROAD	2. Was Decedent Ever in U.S.	21229	agaic Origin? (Specify V		U.S.A.	ican Indian		
permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Iteme 23e or 28e-f ehow any injury or other traumatic event, the Modical Examinar must be notified at once.  To Be Completed by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	Amed Forces?  1  Yes 2  No If Yes, Give Year or Dates:	If Yes, specify Cuban,	Mexican, Puerto Rican,	etc.)	Black, White	, etc.		
ed within 72 hou ygiene. ser than "natura t, the Modical E Completed	15. Decedent's Educi (Specify only highest grade Elementary/Secondary (0-12)		6a. Decedent's Usual Occupati (Give kind of work done du life. DO NOT use retired)	on ring most of working	16b.	Kind of Business/li	ndustry		
ygiene ygiene ver tha t, the	12th grade	College (1-401 54)	TEACHER OF SE			DUCATER			
c even	17. Father's Name (First, Middle, Last)		1	8. Mother's Name (First GERTRUDE F		,			
and Men s marke sumatic	unknown 19a. Informant's Name/Relationship <i>(Typ</i>	e, Print)	19b. Mailing Address (Street an				ip Code)		
t of Health	William B. Holtmen  20a. Method of Disposition  1X Burial 2 □ Cremation 3 □ Re	20b. Place	1214 Kevit Ed e of Disposition (Name of etery, crematory or other place)	., Esltinor		1 and 212 Location - City or T			
Department Important: any injury once.	4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service Licen	MD N	ATIONAL CEMETE: 22. Name and Address WILLIAM C B	of Facility	32	UREL, MA			
Q E & 8	23g. Part 1. Enter the disease, or complete shock, or heart failure. List only one		1206 W NORT	H AVENUE		TERAL HOP	Approximate		
hysician /Medical xaminer	shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	1	econdary to				Interval Betweer Onset and Death 2 HOUR		
physicien and the buriat-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events c. resulting in death) Last	Due to (or as a consequent							
ttending por use as	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 W No 9 □ Unknown	ac. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 4 ☐ Pregnant at time of deatl	ath 3 Ectopic pregnancy			23d. Date of deliving Month	very Day Year		
be o	Part II. Other significant conditions cont	tributing to death but not resultir	ng in the underlying cause given	in Part I. 2	3e. Did tobacco	use contribute to	the cause of death		
certificete has been si irector, page 2 should I					4a. Was an autopsy performed?  ☐ Yes 2 1840	prior to o death?	opsy findings avail- ompletion of cause		
ector.	25. Was case referred to medical examiner?	ospital: 🌉	Other	26. Place of Death Che					
는 물질 F	27. Manner of Death 1 Matural 5 ☐ Pending	1 Unpatient 2 LER	b. Time of Injury Work?	4   Itursing nome	E Residence Describe how inj		ify)		
is after death.  al Director: After the death in by the funeration:  Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home building, etc. (Specify)		28f. Lo	ocation (Street a lity or Town, Sta	and Number or Rulle)	ral Route Number,		
thin 24 hours at the Funeral I impletely filled									
2 c a 0	29b. Signature and title of certifier		29c. License	_	29d. D	ate signed (Month	, Day, Year)		
To t				, at [		- A			
To t com	30. Name and address of person who cor	mpleted cause of death (Item 23	20 (Type, Print)	655 Caton Ave	211	T 29	2006		

DHMH 17 Rev 1/2001

Physic /Medi Exami Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

	Funeral Director
Macrice Winder Harris  Baltimore, Maryland 21215-0036	permit. Peges 1 end 2 should be filed within 72 hours after death with the Maryland Depertment of Heelth and Mental Hygiene. Important: if item 27 ie marked other then "neturel", or iteme 23e or 28e-f ehow ery injury or other traumatic event, the Medical Examinar must be inclined at Once.

Physician /Medical Examiner To the Hospitel or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

•	1- State of Marylar Registrar		partment of H ertificate of L			gienę Rog. Nó	711116	34812
	Decedent's Name (First, Middle, Last)				2. Date of Dea			3. Time of Death
n I	Maurice Winder Harris				October	- 28	2004	1.,,
r	4a. Fecility Name (If not institution, give street and number)	aco	4b. City, Town, or	- 1 - 1	20	~	County of Death	er Lor
	Dorchester General No. 5. Social Security Number 6. Sex 7. Age (In yrs.	last birthda	If Under 1 Year	If Under 24 Hrs.	8. Date of Birt		DOVC V16	place (State or Foreign
	216-16-7345 1⊠M 2□F 82	Yrs.	Months   Davs	Hours Min.	Month, Day 24,	v. Year)	Cou	intry)
	Usuel Residence of Decedent           10a. State         10b. County         10c. Ci	ty, Town or	Location					10d. Inside City Limits
jo	MD Wicomico Qu	antic	o					1 ☐ Yes 2 🛣 No
2	10e. Street and Number		10f. Zip Code			10g. Cit	izen of What Cou	intry?
2	P.O. Box 13-6442 Quantico Road		21856			USA		
מופ	11. Marital Status 12. Was Decedent Ever in U Amed Forces?	I.S. 13	<ol><li>Was Decedent of Hi If Yes, specify Cuba</li></ol>	spanic Origin? (Spe n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	-	14. Race - Amer Black, White	
Dy L	1 Never Married 2 Married 1 AYes 2 No If Yes, Give 194	2	1 ☐ Yes 21☑ No	Specify:			Specify: Whi	-0
מ	15. Decedent's Education	16a. Dec	cedent's Usual Occupa	ation		16b. K	ind of Business/l	ndustry
Completed by Fulleral Director	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)	life	ive kind of work done d a. DO NOT use retired,	)	ng			unk
5	10 none	mete	er tester	18. Mother's Name	(First Middle	Maidae	Cumama)	
0	17. Father's Name (First, Middle, Last)						Surname)	
2	Thurman Banord Harris  19a. Informant's Name/Relationship (Type, Print)	19b. Ma	ailing Address (Street a	Clare Ma	~		or Town, State, Z	(p Code)
	Dorchester General Hospital		Byrn St.			613		
	20a Method of Disposition 20b.	Place of Dis	sposition (Name of crematory or other place		ate	20c. L	ocation - City or T	own, State
Ì	21. Signature Ronal Se ce Licensee Ronal S. Wade		22. Name and Address State Anat Baltimore,	is of Facility omy Board	655 W.	Ва	ltimore	Street
edical Examine	disease or condition resulting in death)  Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consec	quence of):	tic heart					Menerun
Completed by Filysicial interior	d.  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown  d.  23c. If yes, outcome of pregnant 1 Live birth 2 Fet 4 Pregnant at time of 9 Unknown	al death	3 □Ectopic pregnancy 5 □ Other (specify)				23d. Date of deli	very Day Year
	Part II. Other significant conditions contributing to death but not re	sulting in the	e underlying cause give	en in Part I.		obacco Yes 2		the cause of death?
ompiere					24a. Was autoj perio 1 Yes		prior to c death?	topsy findings available ompletion of cause of
2	25. Was case referred to medical			26. Place of Death			1 - 30	
2		ER/Outpat		4   Nursing Ho			6 ☐Other (Spec	ify)
Medical cel micanon.	27. Manner of Death t	28b. Time Injur	ry Worl M 1⊡'	Yes 2 □ No	28f. Location ( City or To	Street a	nd Number or Ru	ral Route Number,
S ISSE	25a. Certifler (Check only one)  1. Certifying Physician: To the best of my king one)  1. Certifying Physician: To the best of my king one one of the basis of examination and manner stated.	owiedga, de	eath occurred at the thr r investigation, in my of	ne, date and place, pinion, death occurr	and due to the red at the time,	cause(s date an	) and manner as d place, and due	etated. to the cause(s)
DIA.	29b. Signature and title of certifier  Paramodus HD		29c. Licenso	a number	-		ite signed (Month	
	30. Name and address of person who completed cause of death (Ite ROSA WATER 300 Juny 100	- 8t	cambridge	R MD 2	1613.			
e r	31. Date filed (Month, Day, Year) \$2. Registrar's Sign	iature	DEALL!					

		1 - State Registrar	•	partment of Health and I ertificate of Death	Mental Hygien Reg. N	/11116	34813
Physici		1. Decedent's Name (First, Middle, Last)  Julius U. Hoke			2. Date of Death Month Doctober 24	ay Year	3. Time of Death 5:15 PM
/Medio Examin		4a. Facility Name (If not institution, give st		4b. City, Town, or Location of Death	1 4	c. County of Death	
Funeral Director		045-12-8324	M 2□ F 7. Age (In yrs. last birthda	Months   Days   Hours   Min.	8. Date of Birth (Month, Day, Yea July 8, 19	9. Birth Cou PA	place (State or Foreig ntry) A
Maryland -f ehow	tor	Usual Residence of Decedent           10a. State         10b. County           MD         Howard	10c. City, Town or				10d. Inside City Limits
or 28a	Director	10e. Street and Number	Oldino	10f. Zip Code		Citizen of What Cou	intry?
or itema 236	Funeral	1 Never Married 2 Married	Amed Forces? 1 ☐ Yes 2X No If Yes, Give	21029 3. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert 1 □ Yes 2 No Specify:	pecify Yes or No-	USA  14. Race - Ameri Black, White	, etc.
nenii 72 mous Nen "natural", Neolesi Ex	Completed by	3 Widowed 4 Divorced  15. Decedent's Educ (Specify only highest grade)  Elementary/Secondary (0-12)	completed) (G College (1-4or 5+)	cedent's Usual Occupation ive kind of work done during most of wor a. DO NOT use retired)		Whi	
Aental Hygier rked other th	To Be Cor	12 17. Father's Name <i>(First, Middl</i> e, <i>Last)</i> Ira Alonza Hoke	4 e		ne (First, Middle, Maide Unverzagt	en Sumame)	
Definition of Fault and Mantal Hygiene. Important: if items 23s or 28s-f ehow important: if item 27 is marked other than "natural", or items 23s or 28s-f ehow any injury or other traumatic event, its Madical Examinar must be notified at once.		Jacqueline Hoke/sp  20a. Method of Disposition  1 Burial 2 Cremation 3 Re	ouse 591	ailing Address (Street and Number or Ru 4 Trotter Road Cla sposition (Name of crematory or other place)	rksville, N		
Departmer important any injury once.		4 ☑ Donation 5 ☐ Other (Specify)  21. Sign sture of Funeral Service License Ronal S	ade livector	22. Name and Address of Facility State Anatomy Boar Baltimore, MD 2120	d 655 W. Ba	altimore	Street
hysician /Medical xaminer		23a. Part1. Enter the disease, or complications shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	A. 1	enter the mode of dying, such as cardial	c or respiratory arrest,		Approximate Interval 8etween Onset and Death
nding physician and use as the burial-transit	dical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of):  Due to (or as a consequence of):				
ttending or use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	ac. If yes, outcome of pregnancy 1	3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of deli	very Day Year
gned b	호	Part II. Other significant conditions con	tributing to death but not resulting in th	e underlying cause given in Part I.		o use contribute to	the cause of death?
ate has b	Completed				24a. Was an autopsy performed 1 Yes 2	prior to c death?	topsy findings availa completion of cause of 2 No
h. After this funeral d	tlon: To Be	25. Was case referred to medical examiner?  1 Yes 2 No H  27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	ospital: 1 Inpatient 2 ER/Outpa 28a. Date of Injury (Month, Day Year) Inju	atient 3 DOA Other: 4 Nursing I	ath (Check only one) Home 5 Residence 28d. Describe how in		city)
within 24 hours efter death.  To the Funeral Director: A completely filled in by the fu	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm building, etc. (Specify)	, street, factory, office	28f. Location (Street City or Town, St		ral Route Number,
within 24 hours effer of To the Funeral Direct completely filled in by	edical	(Check only 2 Medical Examinations)		leath occurred at the time, date and place or investigation, in my opinion, death occ	urred at the time, date a	and place, and due	to the cause(s)
With To T	Σ	29b. Signature and title of certifier	duleto mis	29c. License number		Tobes 2	•
S.	ate	30. Name and address of payson who co	mpleted cause of death (Item 23a) (Ty 32. Registrar's Signature	D38509 HePancient Pky	apunda	o muy la	no 21041

		•	For State Registrar	State of Mary		Department of F Certificate of			£ 0 0	6 34814
			Decedent's Name (First, Middle, La	st)			D 04.11	2. Date of De		3. Time of Death
	Physicia /Medic		SHIRLEY AKERS H	ALL				October		6 4:56 P M
	Examin		4a. Facility Name (If not institution, giv	e street and number)		4b. City, Town, o	r Location of Deatl		4c. County of	
			10525 Sussex Road	d		Ocean Ci			Worcest	er
1	Funeral Director		217 10 0292	7. Age (III	n yrs. last birt	hday) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.		h y, Year)	Birthplace (State or Foreign Country) MD
	and w		Usual Residence of Decedent  10a, State 10b, County	10	Dc. City, Town	or Location		· · · · · · · · · · · · · · · · · · ·		10d. Inside City Limits
	Manyli f eho	ō	Maryland Worcest		cean (					1 ☐ Yes 2√☐ No
	r 28e	rec	10e. Street and Number			10f. Zip Code			10g. Citizen of Wha	at Country?
	th with	Funeral Director	10525 Sussex Rd.			21842			U.S.A.	
	eme r m	ner	11. Marital Status	12. Was Decedent Eve Armed Forces?	r in U.S.	13. Was Decedent of H If Yes, specify Cubi	lispanic Origin? (S an, Mexican, Puert	pecify Yes or No	- 14. Race -	American Indian, White, etc.
215-0036	4 within 72 hours after death with the Maryland jiene than "naturel", or iteme 23a or 28e-1 ehow the Medical Examinar must be notified at	ρ	1 ☐ Never Married 2 ☐ Married  X☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ♣ No If Yes, Give Year or Dates:		1 ☐ Yes X ☐ No	Specify:	,	Specify: V	
ည	72 h	Completed	15. Decedent's E (Specify only highest gra	ducation ide completed)	16a.	Decedent's Usual Occup (Give kind of work done life. DO NOT use retire	nation during most of wor	rking	16b. Kind of Busin	ness/Industry
7	within noe. than	d L	Elementary/Secondary (0-12)	College (1-4or 5+)	hor	<i>life. DO NOT use retire.</i> nemaker	d)		1	
Z 21	Hygi Hygi ther nt,		17. Father's Name (First, Middle, Last	)	1101	nemaker	18. Mother's Nan	ne (First, Middle,	OWN hor	me
<u>a</u>	d ta b	To Be	Harry Albert Aker				Mildred			
Maryland	2 should the and Menter to market eumatic		19a. Informant's Name/Relationship (		19b.	Mailing Address (Street				ate, Zip Code)
	s 1 and 2 should if Health and Men Item 27 is marke other treumatic		Betsy Harrison/da	ughter	19	14 Marlin D	rive Ocea	an City,	MD 21842	
Baitimore,	Peges 1. nent of He ant: If iten ury or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 🛎 Donation 5 ☐ Other (Special	Removal from State	20b. Place of cemeter	Disposition (Name of y, crematory or other place	ce)	Date	20c. Location - Cit	ry or Town, State
Balt	permit. Peges Depertment of h Important: If its any injury or of		21. Sign lure of Funeral Service Lices Ronald S	Wade	tor	State Anat Baltimore	ss of Facility Comy Boar MD 2120	d 655 W.	Baltimo	re Street
п			23a. Part1. Enter the disease, or com- shock, or heart failure. List only	plications that caused the	e death. Do n					Approximate Interval Between
Н	Physician		Immediate Cause (Final disease or condition	>0 V	من					Onset and Death
	/Medical		resulting in death)	Due to (or as a co	onsequence	of):				(//)
я	Examiner	_	Sequentially list conditions,	b. Cenc	morc	) turnor				
	sit sed	nlner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a cr	onsequence (	υτ).				
	and al-trar	Examin	that initiated events resulting in death) Last	c. Due to (or as a co	onsequence	of):				
98/89	licate be executed physicien and s the burial-transit	edical [		d						
_	tifficat ng phy as th	Medi	15.55							
P.O. Box	The law requires that the death certit le has been signed by the attending age 2 should be deteched for use a	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown	23c. If yes, outcome of p 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at tim 9 ☐ Unknown	Fetal death	3 ☐ Ectopic pregnance 5 ☐ Other (specify) _	/		23d. Date o Month	
	s that	by P	Part II. Other significant conditions	contributing to death but n	ot resulting in	the underlying cause giv	ren in Part I.	23e. Did to	obacco use contribu	ite to the cause of death?
ğ	aquire en sig ould b							10	res 2000 3[	□ Probably 4 □Unknown
Vital Records,	sician: The law re certilicete has be lirector, page 2 sh	Completed						24a. Was autop perfo 1 \( \text{Yes} \)	rmed? prio	re autopsy findings available r to completion of cause of th? Yes 2 \sum No
<u>E</u>	ilan: artilice ctor, p	BeC	25. Was case referred to medical exeminer?				26. Place of Dea	ath (Check only o		
<del>-</del>	2 20	2	1 ☐ Yes 2 No	Hospital: 1   Inpatient		tpatient 3 DOA Ott	4 🗆 Nursing H		dence 6 Other	(Specify)
Division of	or Attending Physician: after death. Diractor: After this certilic in by the funeral director,	ë.	27. Manner of Death  1 △ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Ye	9ar) 28b. T	ime of 28c. Injury Wor		28d. Describe I	now injury occurred	
SIC	ttend death ctor: , the f	Icat	2 Accident investigation 3 Suicide 6 Could not be	e 290 Place of Injury	- At home, fa	M 1 ☐	Yes 2 □ No	28f Location (	Street and Number	or Rural Route Number,
2	tal or A	Certification:	4 Homicide determined	building, etc. (	Specify)	mi, street, factory, office		City or Tox	vn, State)	or rulal route rulliper,
	To the Hospital or Attending Pl within 24 hours after death. To the Funarel Director: After th completely filled in by the funeral	Medical		nysician: To the best of m minar: On the basis of ex and manner stated	amination and					
	with To To E	Σ	29b. Signature and title of certifier	0 6		29c. Licens	,		29d. Date signed (A	Month, Day, Year)
,				D.O.			1858		10/27/0	6
			30. Name and address of person who	completed cause of deat	h (Item 23a) (	Type, Print) Why Are S	uer 403	Serli	MD 21	8   1
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's	Signature	Angell ?				

State of Maryland / Department of Health and Mental Hygiens Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month **Physician**  $P^{M}$ Wylie Jones 10 2006 8:30 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Baltimore City 1010 West Baltimore Street 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** Months Days 1 XM 2 ☐ F Hours 74 Yrs. Director 12/24/1932 218-28-6203 Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "naturel", or Items 23s or 28s-f ehow the Medical Examinar coust be notified at MD Baltimore City 1 X Yes 2 ☐ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of Whal Country? 1010 West Baltimore Street 21223 USA by Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2X No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. ss 1 and 2 should be filed within 72 hours after of Health and Mental Hygiene. Item 27 is marked other than "naturel", or Itel other traumatic event, I'm Mudical Examinat 1 Never Married 2 Married Saltimore, Maryland 21215-0036 Specify: 1 ☐ Yes 2 X No Specify: 3 ☐ Widowed 4 P Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8th security guard n/a Baltimore City Schools 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Robert Jones Ruth Wylie ၀ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Sharre Jones / Niece 68 Aberdeen Avenue; Aberdeen, MD 21001 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1
Depertment of HImportent: If Iter
eny Injury or oth 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Mount Zion Cemetery 11/03/2006 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Wylie Funeral Home, P.A. 638 N. Gilmor STreet; Baltimore, Maryland 21217 mean 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner nemi Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence Examine The law requires that the death certificate be executed attending physicien end for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Year Month Day 4☐Pregnant at time of death 5 Other (specify) signed by the a 1 ☐Yes 2 ☐ No 9 Unknown 9 Unknown Part IJ. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 4 Unknown 1 Yes 2 No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate hes b irector, page 2 sl autopsy ormed? 2/X No 1 Yes 2 No the Hospitel or Attending Physician: 25. Was case referred to medical examiner?
1 XYes 2 □ No Be funeral director 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: ၉ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3□ DQA 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After t Certification: Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours e To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier Ziaz Mirza MD 29d. Date signed (Month, Dey, Year) 2006 061901 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Zius Mirza, 6701 Lock Raven Blve Towion, Mrs 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2006 Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2006

			For State Registrar	ate of Maryland / Dep Ce	ertificate of D		Reg		
ı	Physicia	an	Decedent's Name (First, Middle, Last)	rab			2. Date of Death Month	Day Year	3. Time of Death
	/Medic	al	Arnold Alva Ko  4a. Facility Name (If not institution, give street		4b. City, Town, or L	ocation of Death	October	31, 2006 4c. County of Deat	11:38am M
	Examin	er	Carroll Hospital Ce		Westmi	nster		Carro	11
ı	Funeral Director		5. Social Security Number 6. Sex 17 M	7. Age (In yrs. last birthday 89 Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth June 15,	9. Birt	hplace (State or Foreign unity) NJ
	and and		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or L	ocation				10d. Inside City Limits
	Mary a-f sho	tor	MD Carroll		Woodbine				1 ☐ Yes 2 No
	deeth with the Maryland ms 23a or 28a-f show rmust be notified at	ai Director	10e. Street and Number 6800 Dorsey Lane		10f. Zip Code	21797	10g	. Citizen of What Co USA	untry?
5-0036	be filed within 72 hours after deeth with the Marylan it of Hydiene.  It of Hydiene.  It other than "natural", or items 23a or 28a-f show other than "natural", or items 23a or 28a-f show or other than "natural" at a count, the Madical Examiner must be notified at	by Funerai	1 Never Married 2 Married 1	/as Decedent Ever in U.S. med Forces?  —Yes 2 XNo Yes, Give ear or Dates:	. Was Decedent of Hisp If Yes, specify Cuban, 1 ☐ Yes 2 🂢 No	panic Origin? (Spec , Mexican, Puerto F Specify:	city Yes or No- Rican, etc.)	14. Race - Ame Black, Whit Specify: Wh	e, etc.
	natur	letec	15. Decedent's Education (Specify only highest grade con	n 16a. Dec npleted) (Giv	edent's Usual Occupati e kind of work done du DO NOT use retired)	ion iring most of workin	16	b. Kind of Business/	Industry
717	within 72 lene. than na	Completed	Elementary/Secondary (0-12)	0  age (1-40r5+)	Mechanical			Engineer	ing
פ	be filed ntal Hygid od other event, I	Be C	17. Father's Name (First, Middle, Last)		1	18. Mother's Name			
<u> </u>	should b and Menta marked umatic e	To [	Harry Emil Kor				Toykkola		
Mar	0 2 0		19a. Informant's Name/Relationship (Type, F Mrs. Anne Faffley (Da		ling Address (Street and ) Dorsey La			•	Zip Code)
Battimore,	Pages 1 and in the part of Health int: If Item 27 ary or other tr		20a. Method of Disposition  1  Burial 2  Cremation 3  Remo 4  Donation 5 Other (Specify)	20b. Place of Disp cemetery, cri	position (Name of ematory or other place) nty Cremati	on 11/1/2		c. Location - City or kesville,	
Pait	permit. Pages Depertment of i Important: If its any injury or o		21. Signature of Funeral Service Licensee	ridt 5	A TGATO FUNE Sykesville,	RAL HOME MD 21784	& CHAPEI 4 (410)-7	PA (Box 795-1400	195)
			23a. Part1. Enter the disease, or complication shock, or heart failure. List only one care		-				Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	ASHP					Onset and Death  > 59EARS
	/Medical Examiner		resulting in death)	Due to (or as a consequence of):	FAIL	LIDE			>/650
Ļ		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequence of).	17/10	uru=			4 3000
	acuted ind transit	Examin	Cause (Disease or injury that initiated events resulting in death) Last						
68/60,	tificate be executed ig physicien and as the burial-translt	edical Ex	d.	Due to (or as a consequence of):					
			IF FEMALE:			-			
SO BOX	thet the death certi ted by the attending detached for use a	by Physician/N	23b. Was decedent pregnant in the past 12 months?		☐Ectopic pregnancy ☐ Other (specify)			23d. Date of del Month	ivery Day Year
<u>,</u>	w requires thet the been signed by th should be detache		Part II. Other significant conditions contribu	ting to death but not resulting in the	underlying cause giver	n in Part I.		/	o the cause of death?
Hecords	sicien: The law rec certificete hes bee irector, page 2 shou	Completed					24a. Was an autopsy performe	d? prior to death?	utopsy findings available completion of cause of
VII	ysiclen: is certifice director.	Be	25. Was case referred to medical examiner?			26. Place of Death	(Check only one)		
ō	Phy rald	ion: To	January 3 - Francis	Ba. Date of Injury (Month, Day Year)  2 ER/Outpation 28b. Time Injury	of 28c. Injury a	at 2	ne 5 Residence 8d. Describe how	be 6 ☐ Other (Spe injury occurred	city)
DIVISION	4 - B &	Certification;	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	Se. Place of Injury - At home, farm, s building, etc. (Specify)			281. Location (Stre City or Town,	et and Number or Ri State)	ural Route Number,
	To the Hospitel or A within 24 hours efter of the Funeral Dirac completely filled in by	Medical C	(Check only 2 Medical Examiner:	n: To the best of my knowledge, dea On the basis of examination and/or and manner stated.	investigation, in my opi	inion, death occurre	ed at the time, date	and place, and due	to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of confrier	2 Nate	29c. License	number	290	. Date signed (Mont	h, Day, Year)
4	1		Mak (	147	DOO	59552	- /	0/31/2	006
1	15		30. Name and address of person who completed to the complete of the complete o	eted cause of death (Item 23a) (Type MACANNA	B, Print)	2 Rd	UF-STM	IN STER	MD 2/157
10"	Sta Registr		31. Date filed (Month Pay, Year) 2006	32 Registrar's Signature	recei				n. Day, Year) 006 MD 0//57

State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** O'SOAM -2006 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Long View Nursing Home Manchester Carroll Co. If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min 15 M 2 ☐ F 215-07-3022 85 Yrs. Dec. 20,1920 Director Maryland Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City, Town or Location rthan "natural", or Items 23a or 28a-f show the Medical Examinar must be notified at 1 ☐ Yes 2 ☐ No Westminster Directo Maryland Carroll 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 1408 Chazadale Way 21157 USA 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. MXYes 2 □ No If Yes, Give Year or Dates: filed within 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: SpeaWhite þ 3€Vidowed 4 □ Divorced WWII Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12th Accountant Rockland Industries permit. Pages 1 and 2 should be file Department of Health and Mental Hyg Important: If item 27 is marked other any injury or other traumatic event, 1 000.6. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Martha Virginia Burns Harry Klein 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Dennis R. Hoffman Nephew 1408 Chazadale Way Westminster, MD 21157 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Woodlawn Cemetery 11/3/06 Woodlawn, Maryland \* 4 □Donation 5 □ Other (Specify) 21. Signature Funeral Service Licensee Burgee-Henss-Seitz Funeral Home, Inc. 3631 Falls Road Baltimore, Maryland 21211 Approximate Interval Between Onset and Death 23a Part! Enter the disease, or combications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) nelisatatus Pnysician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): physician a Division of Vital Records, P.O. Box 68760, Physician/Medical attending I 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month Day 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9□Unknown 9 Unknown signed l Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown been si 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 2 - No 1 ☐ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☐ No ဥ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After thi 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: 1 Matural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 3 TSuicide 4 THomicide within 24 hours a To the Funeral C t critifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month. Day, Year) 29b. Signature and title of certifier 29c. License number nd address of person who completed cause ol death (Item 23a) (Type, Print) 688 foole 32. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2006 1 - For State Registrar 34818 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 6:15AM **Physician** Beatrice Koch 28, 2006 Oct /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Crawford Retreat Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 89 217-01-5695 10-25-1917 MD Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County MD 1 X Yes 2 □ No Baltimore Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2117 Denison Street 21216 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S Armed Forces? Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 XNever Married 2 Married 1 ☐ Yes 2 No White Saltimore, Maryland 21215-0036 Specify: ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 11 None None 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Unknown Unknown ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Crawford Retreat Records 2117 Denison St., Baltimore, MD 21216 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 M Burial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify) 3 □Removal from State Springfield Cemetery 10/31/06 Sykesville, MD 21. Signature of Funeral Service Licens AATCHT ATUNERALLY HOME & CHAPEL, P.A. (Box 195) Suan Sykesville, MD 21784 (410)-795-1400 23a. Part1. Enter the disease, or complications that daused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final deaston **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** mer Sequentially list conditions, Due to for as a consequence of Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f 9 Unknown 9 Unknown certificate has been signed rector, page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Tyes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 2 **| N** funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Norsing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 NO 2 ER/Outpatient 3 DOA 1 Inpatient Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After t Natural 5 ☐ Pending investigation n 24 hours after death.

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bletely filled in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) completely and manner stated. To the I within 24 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Desay MI) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4419 1B EROI Registrar's Signature 31. Date filed (Month, Day, Year) State NOV 0 2 2006 Registrar

DHMH 17 Rev 1/2001

ORIGINAL

			For State Registrar	State of Maryl		artment of He			giene 006	34819
	Physicia	ın.	1. Decedent's Name (First, Middle, La	1	4			2. Date of Dea	ath Day Year	3. Time of Death
	/Medic		Jering B		edere			october		
	Examin	er	4a. Facility Name (If not institution, giv			4b. City, Town, or	Location of Death		4c. County of Dea	/
	Funeral			Sex 7. Age (In )	yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birt	Talbo	thplace (State or Foreign
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	and w		Usual Residence of Decedent  10a. State 10b. County	10c	. City, Town or Lo	cation				10d. Inside City Limits
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	or 284	Sirec	10e. Street and Number	0 (		10f. Zip Code		i	10g. Citizen of What C	
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	ter de	Funeral Directo	11. Marital Status  1 ▼ Never Married 2  Married	12. Was Decedent Ever i Armed Forces? 1 ☐ Yes 2 図 No	1	Was Decedent of His f Yes, specify Cubar	spanic Origin? (Spe i, Mexican, Puerto	Rican, etc.)	14. Race - Am Black, Whi	
21215-0036	be filed within 72 hours after death with the Maryland Ital Hygiene. Id other than "natural", or items 23a or 28a-f show event, the Medical Evarified in that be indiffed at	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1⊡Yes 2⊠No	Specify:		Specify: W	hite
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Vlar	Menta Menta arked atic ev	108	William Lede	crer	,		Somer	Eilee	20 Wilk	es
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ē	Pages ent of nt: If Ii		1 ☐ Burial 2 ☐ Cremation 3 ☐ `4 ☐ Donation 5 ☑ Other (Speci	Removal from State	cemetery, crer	natory`or other place	)		,	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Evanthat must be putified at once.			Wade Vive ot	or St	Name and Address	s of Facility	655 W.	Baltimore	Street
	89 = 9		James	Marie	Ба	ltimore,	MD 2120.	l		
	ease const		23a. Part1. Enter the disease, of conshock, or heart failure. List only	one cause on each line.	death. Do not ent		, such as cardiac c	or respiratory ar	rest,	Approximate Interval Between Onset and Death
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8760,	cate be executed physician and the burial-transit	calE		d						
9	rtificat ng phy s as th	Physician/Medical	IF FEMALE:		17-					
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o.	it the death certific by the attending p tached for use as	ysic	1 ☐ Yes 2 █ No 9 ☐ Unknown	4□Pregnant at time 9□ Unknown	ordeath 5	Other (specify)				
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Vital Records,		Completed						24a. Was autop	sy prior to	utopsy findings available completion of cause of
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Division	or Attendated after deal	Certification:	4 Homicide determined			eet, factory, office		City or Tov	Street and Number or F vn, State)	lurai Houte Number,
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	the H hin 24 the F mplete	Medical	(ne)	and manner stated.						
)	To To Cor		29b. Signature and little of certifier	hos		29c. License	5027		29d. Date signed (Mon	O 7 9
			30. Name and address of person who	completed cause of death	(Item 23a) (Type.	Print)	1005		ctober	64,6006
			RATICK D'B	rien, MD	506	Idlewild	Ave.	Eastor	1, MD 2	11, Zoolo
	Sta Registr		31. Date filed (Month, Day, Year) NOV 0 2 200	32. Registrar's S	signature	Es)				M
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien ? 34820 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Lucas WILLIAM 1235 06 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death PRINCE GEORGE'S CARE NRSG CENTER CALADYS SPELLMAN CHEVERLY If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 6. Sex 1**⊠**M 2□F 12 Days Hours 577-48-4575 Washington DC Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a State WASHINGTON 1 X Yes 2 ☐ No D.C. 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20009 2013 AVE HAMPSHIRE USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 ☐ Marned 1□Yes 2XNo Specify: BLACK 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) upholsterer furniture 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) unk unk 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20069 19a. Informant's Name/Relationship (Type, Print) HAMPSHIRE AVE WASHINGTON NEW 2013 PAULA WATSON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 □Donation 5 ▼Other (Specify) in state State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, a heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): 23d. Date of delivery Month Day use contribute to the cause of death? □ No 3 □ Probably 4 XUnknown 24b. Were autopsy findings available prior to completion of cause of death? 2□ No 1 Yes 6 ☐Other (Specify) ary occurred

Physician /Medical Examiner To the Hospitel or Attending Physician: The law requires that the death certificate be executed

**Physician** 

/Medical

Examiner

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show eny injury or other traumatic event, the Modified Examinar must be published at ARR.

Baltimore, Maryland 21215-0036

Be Completed by Funeral Director

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physician and the burial-transit for use as signed by the a page within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

After

Division of Vital Records, P.O. Box 68760,

edical Examiner	Sequentially list conditions, if any, feading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	PNEUMONI Due to for as a conseq  DBSTRUCTIV	uence o1): E PULM	ONA	RY DISEA	SE			
by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No	ac. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d 9 ☐ Unknown	il death 3□Ectop				2	23d. Date of delivery Month Day	Year
ed by Pr	Part II. Dther significant conditions cont VENTILATOR DEPE		ulting in the underly	ing caus	e given in Part I.			se contribute to the cause of ☐ No 3 ☐ Probably 4 🗷	deatl Unkr
Completed	RESPIRATORY FAIL	ure			·	per	s an opsy formed? 2 X No	24b. Were autopsy findings prior to completion of death?  1 Yes 2 No	s ava caus
a	25. Was case referred to medical				26. Place of Deat	th (Check only	one)		
0	examiner? 1 ☐ Yes 2 ☑ No	ospital: 1 🗆 Inpatient 2 🗆	ER/Outpatient 3	DOA	Other: 4 Nursing Ho	ome 5 Re	sidence 6	S □Other (Specify)	
atlon: 1	27. Manner of Death  1 Natural  2 Accident  2 Accident	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M		Injury at Work? 1 □ Yes 2 □ No	28d. Describe			
Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Special	ome, farm, street, fa fy)	ictory, of	fice		(Street and own, State,	d Number or Rural Route Nu )	mber,
Medicai (		sician: To the best of my knoner: On the basis of examina and manner stated.						and manner as stated. place, and due to the cause	(s)
ž	29b. Signature and title of certifier	2 0		29c. Li	cense number		29d. Dat	e signed (Month, Day, Year)	

Registrar

31. Date filed (Month, Day, Year)

30. Name and address of person

OPHNELL

Huel Cheury



who completed cause of death (Item 23a) (Type, Print)

	For State Registrar	State of Marylan	d / Department of Certificate of			iene20	06 34821		
8)	1. Decedent's Name (First, Middle, L	ast)			2. Date of Dea Month	th	3. Time of Death		
Physiciar /Medica	101 ( V 10 1		Longus		October	28	2006 09:56 PM		
Examine	4 5 30 44 45 45 45 45 45	ve street and number)	J 4b. City, Tow	n, or Location of Deat	h	4c. County	of Death		
Funeral Director	210 73-0140	Sey 7. Age (In yrs. 1			8. Date of Birth Month, Day 06/13/	, Year)	Birthplace (State or Foreign Country)     MD		
put	Usual Residence of Decedent  10a, State  10b, County	10c Cib	y, Town or Location	0			10d. Inside City Limits		
e Maryla Se-f eho				more City			1. Yes 2 No		
h with th	100. Street and Number 3009 Carlisle Avenue		10f. Zip Cod	e 21216	1	0g. Citizen of	What Country? USA		
Ind 21215-0036  be filed within 72 hours after death with the Maryland ital Hygiene. Id other then "natural", or items 23a or 28e-f show event, the Madical Examinancial Remodified at	MD  10e. Street and Number  3009 Carlisle Avenue  11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	S. 13. Was Decedent of the Yes, specify C	of Hispanic Origin? (Scuban, Mexican, Puerl No <i>Specify:</i>	pecify Yes or No- to Rican, etc.)	Bla	ce - American Indian, ck, White, etc. cy: Black		
Maryland 21215-0036 and 2 should be filed within 72 hours aff the and Mental Hygiene. 27 is marked other then "naturel, or reternmetic event, the Madical Exami	15. Decedent's (Specify only highest g  Elementary/Secondary (0-12)  n/a	rade completed)  College (1-4or 5+)	16a. Decedent's Usual Oc (Give kind of work do life. DO NOT use re	ne during most of wor tired)	rking	16b. Kind of B	usiness/Industry		
laryland 2 2 should be filed and Mental Hygi is marked other aumatic event, I	17. Father's Name (First, Middle, Las Cedric Timothy Longu	•		18. Mother's Nar	ne (First, Middle, i Norrisha S	Maiden Suman	me)		
end 2 shou ealth and N m 27 is man	19a. Informant's Name/Relationship Norrisha S. Withers		19b. Mailing Address (Str.	eet and Number or Ru Le Avenue: Ba					
MOFe, Pages 1 elent of Hearn of Hearn ry or othe	20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3  4 ☐ Donation 5 ☐ Other (Spec	20b. P ☐Removal from State	dace of Disposition (Name of emetery, crematory or other By Memorial Park	place)	Date		- City or Town, State		
Baltim permit. Pa Depertmen importent: any injury once.	21. Signature of Funeral Service Lice	Jones	22. Name and Ad	· V		uneral Home, P.A. imore, Maryland 21217			
Physician /Medical	23a. Part 1. Enter the disease, or co shock, or heart failure. List onl Immediate Cause (Final disease or condition resulting in death)	nplications that caused the death y one cause on each line. a. Complication	n. Do not enter the mode of		or respiratory arr	est,	Approximate Interval Between Onset and Death 4 days		
8760, mate be executed by sicien and the burial-transit and the buri	S * uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b.  Due to for as a consequence.  Due to for as a consequence.  Due to for as a consequence.	uence of):						
death certification of for use as	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  Part II. Other significant conditions	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of do	death 3 Ectopic pregna				ite of delivery onth Day Year		
cords, P.O w requires that the been signed by th should be detache	Part II. Other significant conditions  17150 my 2	contributing to death but not resu	ulting in the underlying cause	given in Part I,	23e. Did tol	V	tribute to the cause of death?		
The law are has b page 2 s	Delete De				24a. Was a autops perform	negt?	Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No		
of Vital F Physician: Th This certificate ral director, pag	25. Was case referred to medical examiner?	Hospital: 1/		-	ath (Check only on	θ)			
Division of Vita Vita Hospital or Attanding Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	1 Yes 2 No  27. Napner of Death 1 Natural 5 Pending 2 Accident investigati	28a. Date of Injury (Month, Day Year)	28b. Time of lnjury 28c. In	Other: 4 Nursing H njury at Work?	ome 5 Reside				
Divisi	27. Nanner of Death  12 Natural  2 Accident investigate  3 Suicide 6 Could not determine	be 300 Blood of Injury. At he	ome, farm, street, factory, offi	сө	28f. Location (St City or Town	per or Rural Route Number,			
ne Hospital of 24 hours after Funeral Dietely filled in the funeral Dietely filled in the funeral Column 1	g 29a. Certifier 1 Certifying F	thysician: To the best of my knowniner: On the basis of examinational and manner stated.	wledge, death occurred at thition and/or investigation, in m	e time, date and place by opinion, death occu	e, and due to the ca arred at the time, d	ause(s) and ma ate and place,	anner as stated. and due to the cause(s)		
To the To the complet	29b. Signature and title of certifier			ense number		-	d (Month, Day, Year)		
	Janu M. Schwar	h MD	RE	5-000	0	ctober	28, 2006		
1	30. Name and address of person who Jamic M Schwar-		23a) (Type, Print) OKINS Hospital	600N Wolfe	St Bal	Imore	28, 2006 - MD 21287		
State Registra	e 31. Date filed (Month, Day, Year)	32. Registrar's Signa	ture	F	<del>-</del>				

			1- For Amend #22 Per State of Maryland	/2)epa Cen	rtment of H	lealth and M Death		Reg. No.	106	34822		
	Physicia /Medic Examin	al	Decedent's Name (First, Middle, Last)  4a. Facility Name (If not institution, give street and number)		Met. 4b. City, Town, or	OW Location of Death	2. Date of De. Month Octobe	- 29	Year 2006 nty of Death	3. Time of Death		
	Funeral Director		The Johns Hopkins Hosp, to.         5. Social Security Number       6. Sex       7. Age (In yrs. last         215-74-7123       1 M 2□ F       64	birthday)_ Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bird (Month, Da Feb 28	, 1942	9. Birthr	place (State or Foreign ntry) .nois		
e Maryland	Ba-I show	ctor	Usual Residence of Decedent   10a. State   10b. County   10c. City, To							10d. Inside City Limits 1 ⊠Yes 2 ☐ No		
ath with th	23a or 2	Funeral Director	10e. Street and Number 4002 Erdman Avenue		10f. Zip Code 21213			U.S.A.	•			
OURs after des	rel', or items Examiner m	by	11. Marital Status  1 □ Never Married 2 □ Married  1 □ Never Married 2 □ Married  3 □ Widowed 4 ☒ Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Yes 2 ☒ No If Yes, Give Year or Dates:	-	/as Decedent of H Yes, specify Cuba ☐ Yes 2(X) No	ispanic Origin? (Spen) In, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)		lace - Americ lack, White, cify: Whit	etc.		
at yiailiu < 1 < 1 > 1 > 0000 should be filed within 72 hours after death with the Maryland	Depertment of Heelth and Mental Hygiene. Important: or items 23s or 28s-1 show important: if item 27 is marked other than "naturel", or items 23s or 28s-1 show ery injury or other treumatic event, the Medical Examinational handling at once.	Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)	6a. Decede (Give k life. D Dwner	ent's Usual Occup and of work done o O NOT use retired	ing	16b. Kind of Business/Industry Outdoor Amusement					
uld be file	Mental Hygirked other	To Be C	17. Father's Name ( <i>First, Middle, Last</i> )  Casey Metlow			18. Mother's Name Amelia E		Maiden Sum	ame)			
and 2 sho	elth and N 127 is ma er treuma		19a. Informant's Name/Relationship (Type, Print)  Sophia Metlow/Niece  1 4	19b. Mailing +002 F	g Address <i>(Street a</i> Erdman Av	and Number or Rura Tenue Balt	I Route Numbe	or, City or Tow MD 2121	n, State, Zip L3	o Code)		
Dallimore, Jermit. Pages 1.8	tment of He tant: if item		4 Donation 5 Other (Specify) Weste	ern Ce	ition (Name of atory or other place emetery	11-1-			more,	Maryland		
B D	Deper impor		Woods Thelle	27	719 Hammo	onds Ferry	Rd. L	ansdowr		of Lansdowne 21227 Approximate		
fou,	Physician /Medical Examiner prize sicien and prize-transit		23a. Part I. Enter the disease, or complications that caused he death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on eachdrie.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):									
the death certifica	been signed by the ettending physicien and should be detached for use as the buriat-transit	Physician/Med		1 ☐ Live birth 2 ☐ Fetal déath 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)						23d. Date of delivery Month Day Year		
v requires that	en signed b	þ	Part II. Other significant conditions contributing to death but not resultin							tobacco use contribute to the cause of death?  Yes 2 No 3 Probably 4 Unknown		
The is	ete has page 2	e Completed	25. Was case referred to medical	24a. Was an autopsy performed 1 Types 20 N. s case referred to medical 25. Place of Death (Check only one)								
OF VI	ar this cert eral direct	To B	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/ 27. Manner of Death 28a. Date of Injury 28	Outpatient	3 DOA Oth	er: 4 Nursing Ho		dence 6 🗆 C		(y)		
or Attending	within 24 hours after death.  To the Funeral Director: After this certifical completely filled in by the funeral director,	Certification:	2 Accident investigation	Accident investigation  Accident investigation  Suicide 6 Could not be determined and experiment and accident process. Suicide 6 Could not be determined.								
Hospital	24 hours	edical Ce	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowled to the basis of examination and manner stated.	and/or inve	estigation, in my o	pinion, death occurr	ed at the time,	date and place	e, and due to	o the cause(s)		
Toth	within To th compl	Me	29b. Signature and title of certifier  Medical f	Date	29c. Licenson	number		29d. Date sign	ned (Month,	Day, Year) 9, 2006 13,nd21287		
			30. Name and address of person who completed cause of death (Item 23	Ba) (Type, P	Print) 00 No-4h	Wolfest	roet B	altimore	Mocu	13nd21287		
	Sta Registr		31. Date filed (Month, Day, Year) 2 2006 32. Figure 32. Figure 2 32. F	A	red				y			

			For Stete Registrar	State of Maryland		rtment of H ificate of L			ien <del>e</del> 005	34823
			Decedent's Name (First, Middle, Last)			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		2. Date of Deat Month		3. Time of Death
1	hysici Medio/		Lillie	MANN			La dia di Dania	octoba	4c. County of De	o 11(33 /1-14
	Examin	er	4a. Fecility Name (If not institution, give s Clinton Nursing &			Clinto	Location of Death		Prince G	
	uneral rector		Social Security Number 6. Sex		st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, July 21	Year) 9. E	Birthplace (State or Foreign Country) unk
and	*		Usual Residence of Decedent  10a. State 10b. County	10c. City,	Town or Loca	ation			<u> </u>	10d. Inside City Limits
Maryl	of sho	tor	MD Prince G	eorge's C1	inton					1 ☐ Yes 2 ☑ No
ith the	or 28c	Director	10e. Street and Number			10f. Zip Code		1	0g. Citizen of What	,
eath w	18 23a	Funeral	9211 Stuart Lane	2 Was Decedent Ever in U.S.	13. W	as Decedent of Hi	20735	ecify Yes or No-	US 14. Race - A	merican Indian,
5-0036 72 hours after death with the Maryland	"neturel", or items 23a or 28e-f show edical Examiner must be natified at	þ	1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in U.S Armed Forces? 1 Yes 2X No If Yes, Give Year or Dates:		Yes, specify Cuba □ Yes 2][ No	spanic Origin? (Spen, Mexican, Puerto Specify:	Rican, etc.)	Black, W	hite, etc. black
		Completed	15. Decedent's Educ (Specify only highest grade	completed)	(Give k	ent's Usual Occupa ind of work done of O NOT use retired	turing most of worki	unk <sub>ing</sub>	16b. Kind of Busine	ss/Industry unk
Z I Z I Z within giene.	er than	Somp	Elementary/Secondary (0-12) unk ur	College (1-4or 5+)						
Iand Z	rked othi	To Be (	17. Father's Name (First, Middle, Last)			unk	18. Mother's Name	e (First, Middle, I	Maiden Sumame)	unk
Mary d 2 shou th and N	is ma	Г	19a. Informant's Name/Relationship (Type						, City or Town, State	e, Zip Code)
e, R	em 27 ther to	- 91	Clinton Nursing & 20a. Method of Disposition	20b. Pla	ace of Disposi	ition (Name of			MD 20735 20c, Location - City	or Town, State
timor t. Pages tment of	ent: }	3	1 ☐ Burial 2 ☐ Cremation 3 ☐ R '4 ☐ Donation 5 🖾 Other (Specify)	in state		atory or other place				
Dartmit. F	any in		21. Signature Funeral Solvice License	ax, Digestor	St. Bal	ate Anate timore,	omy Board MD 2120	655 W.	Baltimore	e Street
			23a. Part1. anter the disease, or complishock, or heart failure. List only or Immediate Cause (Final	e caus each line.						Approximate Interval Between Onset and Death
/M	sician edical		disease or condition resulting in death)	Due to (or as a consequent	4 5 t. f	is 17	eummi	a		1
Exa	miner	<u>.</u>	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequence	Turk	na nucl	oticisme	1572 a	vme	-
pein	d ansit	Examiner	cause. Enter Underlying Cause (Diseese or injury that initiated events							II,
<b>58 / 5U,</b> ficate be executed	physician and s the burial-transit		resulting in death) Last	Due to (or as a conseque	ence of):					
• ₹	ng phy as the	Aedical	IE EENALE.							
O. BOX	been signed by the attending should be detached for use a	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 TNo "9 ☐ Unknown	3c. If yes, outcome of pregnan 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown	death 3 □8	Ectopic pregnancy Other (specify)			23d. Date of Month	delivery Day Year
ecords, P.O law requires that the	n signed by Jid be deta	by	Part II. Other significant conditions con		iribute to the cause of death?  3 Probably 4 Unknown					
r å	has 30 2	Completed						24a. Was a autops perform	sy prior med? death	autopsy findings available to completion of cause of ? /es 2 \sum No
OT VITA Physician:	is certificate director, pag	Be	25. Was case referred to medical examiner?	ospital:		Other	26. Place of Deatl			
→ ×	. <u>e</u> ≅.	n; To	27. Manner of Death	1   Impatient 2   E	ER/Outpatient 28b. Time of Injury	3 DOA 28c. Injun Work	at Nursing Ho		ence 6 Other (Sow injury occurred	(pecify)
DIVISION I or Attending	tor: Af the fur	catlo	1 Accident 3 Suicide 6 Could not be			M 1 []	Yes 2 □ No	28f Location (St	treet and Number or	Rural Route Number,
DIVI tal or At	el Direc ed in by	Certification;	4 Homicide determined	28e, Place of Injury - At hor building, etc. (Specify)		et, ractory, office		City or Town		Transfer footo (Various),
ne Hospi	To the Funerel Director: After th completely filled in by the funeral	edical	29a. Certifier 1 Certifying Physical (Check only one) 2 Medicel Exemination	sicien: To the best of my know ner: On the basis of examinati and manner stated.	vledge, death on and/or inve	occurred at the tin estigation, in my of	ne, date and place, pinion, death occurr	and due to the c red at the time, d	ause(s) and manner late and place, and o	r as stated. due to the cause(s)
To the within	To the	Σ	29b. Signature and title of certifier	A DUM		29c. License		,	9d. Date signed (Mo	
				mpleted cause of death (Item	23a) /Tuna 17	D S	7 600		october	17, 200
			William T. TAA	WELMO II	101 LI	ringglan	Ropd .	fort w	1ASH ing ta	n, mayland
	Sta Regist		31. Date filed (Month, Day, Year) NOV 0. 2. 2006	32. Registrar's Signat	ure?	,			•	

	•	For State Registrar	State of Ma	ryland / D	epartmer Certificat	t of H	ealth and Death	d Mental Hyg	ien <b>e</b> () (	06	34824	
		Decedent's Name (First, Middle, Last)						2. Date of Dea Month	h Day	Year	3. Time of Death	
Physicia /Medic		EILEEN	G.		MOULDS			10		006	7:30 a <sup>M</sup>	
Examin	4 6	4a. Facility Name (If not institution, give st OAK CREST VILLAGE			· ·	Town, or <b>KVIL</b> I	Location of De	eath	4c. County BALT			
Funeral Director		210 12 4005	7. Age	(In yrs. last birtl	rs. If Unde Months	Days	If Under 24 H Hours M	Irs. 8. Date of Birth in. (Month, Day 04 24 1	Year)	9. Birthpla Countr MD	ice (State or Foreign y)	
2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or flems 23a or 28a-f show eumatic event, the Modical Examinar must be notified at	Director	Usual Residence of Decedent  10a. State 10b. County  MD BALTTMORE  10e. Street and Number		10c. City, Town or Location  ROSEDALE  10f. Zip Code			1		10d. Inside City Limits 1 □ Yes 2 XNo of What Country?			
	by Funeral	1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent E Armed Forces? 1 Yes 2 XN If Yes, Give Year or Dates:	16a.	13. Was Dece If Yes, spe 1 \( \triangle Yes\)	2 X No	Specify:	(Specify Yes or No- erto Rican, etc.)	Bla	ce - America ck, White, et y: WHIT	rE	
Man y failu. A La La Jougo de shours al mand Mandal Hygiens al marked other than "natural", or treumatic event, the Madical Exert	Completed	(Specify only highest grade Elementary/Secondary (0-12) 12	Completed) College (1-4or 5-	-)	(Give kind of wi life. DO NOT L SONAL I	se retired,			ELECTR	IC CON	1PANY	
should be filed ind Mental Hygie	To Be (	17. Father's Name (First, Middle, Last) HENRY GREENSF	ELDER				KATHE		PTAK			
₹25 €		19a. Informant's Name/Relationship (Type HELEN SANTONI/SIST		57	11 BENT	ON HI		AVE., BAL	ro.,MD	21206	5	
Definitions, in permit Pages 1 and 2 Department of Health important: If itam 27 I any injury or other tra		20a. Method of Disposition 1   Burial 2 □ Cremation 3 □ Re 4 □ Donation 5 □ Other (Specify)	emoval from State	cemeter	Disposition (Na y, crematory or EDEFMER	other place		Date 02-2006 I	20c. Location	•		
permit. Pages Department of P Important: If its any injury or of		21. Signature of Funaral Service License	8		22. Name a			CVACH/ROSI , ROSEDAI				
Physician /Medical Examiner		23a. Part1. Erfer the disease, or complice shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	A SC	the death. Do note:  VO  consequence of		de of dying	g, such as card	dac or respiratory ari	est,		Approximate Interval Between Onsel and Death	
The law requires that the deeth certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	dical Examiner	Sequentially list conditions, if an easting to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		consequence o								
that the deeth certific ed by the attending p detached for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	3c. If yes, outcome of 1 Live birth 2 4 Pregnant at 9 Unknown	2 Fetal death	3 □Ectopic p					ate of deliver	y Day Year	
w requires that the bear signed by should be detact	by	Fair III Office significant continuos commoding to deally out for section and anything cause given in year.									te to the cause of death?  Probably 4 Onknown	
lor Attending Physicien: The law requires to after death.  Director: After this certificate has been signed in by the funeral director, page 2 should be controlled.	Completed	,						24a. Was a autop perfor	med?	prior to com death?	sy findings available pletion of cause of	
cien: ertific ector,	Be	25. Was case referred to medical examiner?	ospital:			104	-	Death (Check only or	10)			
ling Physi	lon: To	27. Manne eath 1 Matural 5 Pending	nt 2 ER/Outpatient 3 DOA Other: 4 Jursing ry (Year) 28b. Time of Injury (Mark? Mark? No. 1 Pes 2 No. 1			Home 5   Residence 6   Other (Specify)   28d. Describe how injury occurred						
To the Hospital or Attending Physicien: The I within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 4 Homicide 1998. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route City or Town, State)			Route Number,	
To the Hospital within 24 hours a To the Funeral I completely filled	Medical C	29a. Certifier 1 Certifying Phys (Check only 2 Medical Examin		examination and				ace, and due to lhe o				
To the within To the comp	M	29b. Signature and title of certifier	2	No.	29	DJ	3115		OC to Lu		lay, Year) Hh 2006	
10		30. Name and address of person who so	mpleted cause of de	eath (Item 23a) (	Type, Print)	60	Pal	kulle r		1254		
Sta Regist		31. Date filed (Month, Day, Year) NOV 0 2 201	32. egistra	r's Signature	Joseph.	,						

34825

		•	1 = For State Registrar	Cer	tificate of Death	Reg. f	No.	
	Physicia	an	1. Decedent's Name (First, Middle, Last)  BERNICE M	JED C		2. Date of Death Month NOVEMBE		3. Time of Death 3: 2c A M
	/Medic Examin	al .	4a. Facility Name (If not institution, give st HARBOR HOSP	reet and number)	4b. City, Town, or Location of Death		4c. County of Death	3. ×C A **
The second second	Funeral Director		5. Social Security Number 3 6. Sex 10 - 36 - 5154 10	7. Age (In yrs. last birthday) Yrs.	If Under 1 Year   If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Yea	9. Birthp Coun	lace (State or Foreign try)
	e Maryland a-f show	ctor	Usual Residence of Decedent  10a. State  10b. County  ANNE ARI	10c. City, Town or Lo	JBURNIE			0d. Inside City Limits 1 ☐ Yes 2 ☑ No
	3a or 28	al Director	10e. Street and Number 406 MORNINGSIDE	DR	10f. Zip Code 2 (06)	10g. (	Citizen of What Coun	try? <b>1</b> •
036	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or iteme 23a or 28a-f show other traumatic event, the Medical Examinar must be multified at	by Funerai	11. Marital Status 11. Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces?	Was Decedent of Hispanic Origin? (Sif Yes, specify Cuban, Mexican, Puerton 1 Yes 2 No Specify:	pecify Yes or No- o Rican, etc.)	14. Race - Americ Black, White,	
21215-0036	within 72 ho ene. than "natur ne Medicel	Completed	15. Decedent's Educa (Specify only highest grade	completed) (Give	dent's Usual Occupation kind of work done during most of wor DO NOT use retired)	king 16b.	RETAIL	,
Maryland 2	should be filed nd Mental Hygin marked other umatic event, II	To Be Co	17. Father's Name (First, Middle, Last) HENRY C. MEK	CRITTSR.	18. Mother's Nan ANNA	me (First, Middle, Maid M. FLU		
	s 1 and 2 sho I Health and I tem 27 is mu		19a. Informant's Name/Relationship (Typ)  KOBERT MYEES JR  20a. Method of Disposition	SON P.D.B	ng Address (Street and Number or Ru 22 293 CLAYS Busilion (Name of majory or other place)	eq. PA - 16	y or Town, State, Zip	
Baltimore,	permit. Pages Department of Importent: If it eny injury or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)  21. Signature Funeral ervice ☐ Censed	ANATONY 6	Name and didress of Facility Daugherty Family Funeral F			45
68760,	Physician pe executed // Medical Examiner // Set the prival-transit	Medicai Examiner	23d. Part1. Enter the disease, or complete shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  d.	ations that caused the static. On not entered automorphisms.  A CUTE RETVAL  Due to (or as a consequence of):  CHRONIC KIDNE  Due to (or as a consequence of):  Due to (or as a consequence of):	FAILURE	or respiratory arrest,	21166	Approximate Interval Between Onset and Death 7 DA YS
Box	The law requires that the death certif ste hes been signed by the attending bage 2 should be detached for use a	Physician/Me	IF FEMALE: 23b. Was decedent pregpant in the past 12 mortins? 1 □ Yes 2 ☑ No 9 □ Unknown		□Ectopic pregnancy □ Other (specify)		23d. Date of delive Month	ory Day Year
rds, P.O.	quires that t n signed by uld be deta	þ	Part II. Other significant conditions cont DIABETES MELLIZ HISTORY OF AUTOI	ributing to death but not resulting in the $u$	nderlying cause given in Part I.  #POTHYROLDISM;	23e. Did tobacc	o use contribute to the	
Reco		Completed	HISTORY OF AUTOI	MMUNE LIVER DIS	SEASE	24a. Was an autopsy performed'	prior to cor death?	psy findings available npletion of cause of 212 No
of Vital Records,	Physician: this certific ral director,	To Be	25. Was case referred to medical examiner?  1  Yes 2 No Ho  27. Manner Death	pospital: 1 in npatient 2 ER/Outpatier 28a. Date of Injury 28b. Time o	nt 3 DOA Other: 4 Nursing H	ith Check only one ome 5 Residence 28d. Describe how in		<i>(</i> )
Division	ding Afte fune	Certification:	1 Liviatural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	(Month, Day Year) Injury  28e. Place of Injury - At home, farm, str building, etc. (Specify)	Work? M 1 ☐ Yes 2 ☐ No		and Number or Rura	l Route Number,
۵	To the Hospital or Attan within 24 hours after deal to the Funaral Director: completely filled in by the	edicai Cer		ician: To the best of my knowledge, deat er: On the basis of examination and/or in and manner stated.				
	To the within 2 To the comple	Med	29b. Signature and title of certifier  MID -	and marrier states.	29c. License number	!	Date signed (Month,	
	5		30. Name and address of person who cor	mpleted cause of death (Item 23a) (Type, SONTH: H	Print) HANOVER ST. BY	ALTIMORE,	MD 212	25.

DHMH 17 Rev 1/2001

State Registrar

31. Date filed (Month, Pay, Year) NOV 0 2 2006

			1 - For State Registrar	State of Marylan	d / Depai <i>Cert</i>	rtment of ificate of	Health and Death		iene2 () () () og. No.	34826
	Physici /Medic		Decedentie Name (First, Middle, Last)		ing			2. Date of Death	26 28	06
	Examir Funeral Director	ier	5. Social Security Number 6. Sex	imore st	, _	4b. City, Town,  If Under 1 Yea  Months Day:		Eity  B. Date of Birth (Month, Day,	4c. County of Dea	
	D	_	Usual Residence of Decedent  10a. State 10b. County  MD 1mkm		y, Town or Loca		Maryland	07/25/1	.940	10d. Inside City Limits 12 Yes 2 No
	with the M a or 28a-f be notifie	Director	MD unkno			10f. Zip Code	21223	10	Og. Citizen of What C	
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Heelth and Mental Hygiene. Depertment of Heelth and Mental Hygiene important: If item 27 is marked other then "natural", or iteme 23a or 28a-f ehow entry injury or other traumette event, the Medical Examinant could be multipled at ance.	Completed by Funeral		2. Was Decedent Ever in U. Armed Forces? 1  Yes 2 No If Yes, Give Year or Dates:	lf '	as Decedent of Yes, specify Cu	Hispanic Origin? (Sban, Mexican, Puer Dispectly:	Specify Yes or No- to Rican, etc.)	USA  14. Race - Am Black, Whi  Specify: Bla	ite, etc.
21215-0036	d within 72 ho giene. or then "natur	completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) 5th		16a. Decede (Give ki life. Do	nnt's Usual Occi ind of work doni O NOT use retir laborer	upation e during most of wo ed)	rking	16b. Kind of Business unknown	s/Industry
Maryland	buld be file Mental Hy, arked other etic event,	To Be C	17. Father's Name (First, Middle, Last) Daniel Manning	g				me (First, Middle, M Dorothy S	Stewart	
, Mar	and 2 sho eelth and m 27 fs m		19a. Informant's Name/Relationship (Type Cynthia Manning / Siste	er	160	8 Gwynns		vay; Baltimo	City or Town, State, ore, Maryland	1 21217
Baltimore,	. Pages 1 Iment of H lant: if ite jury or otl		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	lace of Disposi emetery, crema int Zion	tory or other pl	1 1 .		Raltimore, Ma	
Ball	Depermit Depermit fmpor eny in		- Constitution of	Mas			llmor Street		al Home, P.A., Maryland	<sup>A</sup> . 21217
	Physician /Medical Examiner	ilner	23a. Part1. Enter the disease, or comblic shock, or heart failure. List only one immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions. If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Non-small Ce  Due to (or as a consequence to (or as a consequence)	ll Lung uence of):			c or respiratory arre	St,	Approximate Interval Between Onset and Death 2 MONTHS
8760, <	cate be executed physician and the burial-transit	dical Examiner	that initiated events resulting in death) Last	Due to (or as a consequ	uence of):					
P.O. Box 6	The law requires that the death certific ate hes been signed by the attending p page 2 should be detached for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	Bc. If yes, outcome of pregna 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown	death 3 E	ctopic pregnan Other (specify)	су		23d. Date of de Month	livery Day Year
rds, P	w requires that been signed t should be det	þ	Part II. Other significant conditions cont	tributing to death but not resu	ulting in the und	lerlying cause g	iven in Part I.	1		o the cause of death?
Division of Vital Records,	iclan: The law re certificate hes be rector, page 2 sh	Completed						415-55 P. 15-50-10	prior to death?	utopsy findings available completion of cause of 2 No
<u> </u>	/sicial	To Be	25. Was case referred to medical examiner?	ospital:	ER/Outpatrent	3 DOA C		ath Check only one	nce 6 □Other (Spe	-4.1
ion of	Attending Physician: It death. ector: After this certifice by the funeral director, i		27. Menner of Death 1 🗋 Natural 5 🗌 Pending 2 🗀 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Inju	ury at ork?	28d. Describe how		спу)
Divis	taf or Attents after death	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	ome, farm, stree	t, factory, office		28f. Location (Str. City or Town,	eet and Number or R State)	ural Route Number,
	To the Hospital or Attending Physician: The within 24 hours after dath. To the Funeral Director: After this certificate h completely filled in by the funeral director, page	Medical	one) 2 Medical Examin	ician: To the best of my knower: On the basis of examinat and manner stated.	wiedge, death o	occurred at the stigation, in my	ime, date and place opinion, death occu	e, and due to the cau urred at the time, da	use(s) and manner a te and place, and du	s stated. e to the cause(s)
	To the To the comple	Σ	29b. Signature and tiple of perifier	7		D005	se number 55065		d. Date signed <i>(Moni</i> November 1	,
	1		30. Name and address of person who con Greenebaum Can					lman, M.D 8, Baltim		201
	Sta Registr		31. Date filed (Month, Day, Year)	32. Redištrar's Signal		south o				

06-08029 Please Type or Print in Black Indelible Ink Rose Newsome State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg No Registrar Physician/ 1. Decedent's Name (First, Middle,Last) 2. Date of Death NEW SOME Month Day October 25, 2006 MARIE Medical Examiner 1547 hrs 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4325 Seidel Avenue Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8 Date of Birth(MM/DD/YYYY) 9 Birthplace (State or Foreign Country) **Funeral** Months Days Hours Director 220 76 3254 Usual Residence of Decedent 10d Inside City Limits BAltiMo RE 1 Yes 2 No Pages I and 2 should be filed within 72 hours after death with the Maryland near of Health and Mental Hygiest has martifuled 21's narked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once or other traumatic event, the Medical Examiner must be notified at once Director 10e. Street and Number SEIDE USA 21206-Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black Armed Forces? 1 Never Married 2 Married Yes 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 No specify: þ r Dates 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) Baltimore, MD 21215-0036 12 17. Father's Name (First, Middle, Last) MEWSOME VIRGINIA JONES

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1503 N. PA+1KRSON PARK AVE BAHZ ME

21213 19a Informant's Name/Relationship (Type, Print) ပ 20b. Place of Disposition (Name of cemetery) 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State crematory or other place) Important: I GREEN Many CEA 11/3/06 21. Signature of Funeral Service Licensee 23a. Part I Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** failure. List only one cause on each line Between Onset and /Medical Death Immediate Cause (Final disease Fatty liver Examiner or condition resulting in death) Due to (or as a consequence of). Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): Examiner (Lisuase of injury that initiated events resulting in death) Last Due to (or as a consequence of). and Physician/Medical X<sup>AME</sup> perFh, 23a, PII, 27, perME, g862 12/7/06 TT X UNPENDED Division of Vital Records, P.O. Box 68760, IF FEMALE 23d Date of delivery 23b. Was decedent pregnant in the Fetal death Live birth 3 Ectopic pregnancy Dav Year past 12 months? Pregnant at time of death 5 Other (Specify) Hospital or Attending Physician: The law requires that the death 1 Yes 2 No 9 V Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No. 3 Probably 4 V Unknown Chronic alcoholism and drug use Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? ✓ Yes 2 No 1 🗸 Yes 25. Was case referred to medical 26.Place of Death (Check only one) Hospital: 1 Inpatient 2 Other<sub>4</sub> ER/Outpatient 3 DOA Nursing Home 5 After this Residence 6 Other Scene 1 🗸 Yes 2 No 27. Manner of Death 28a Date of Injury (Month, Day, Year 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 Pending 1 Yes 2 No Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City Could not be Suicide or Town, State) determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started Medical 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

within 24 hours after death To the Funeral Director:

and address of person who completed cause of death (Item 23a) Theodore M. King, Jr., MD.

32. Régistrar's Signature

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

29d. Date signed (Month, Day, Year)

October 26, 2006

29c. License number

O.C.M.E

State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

GOBALL S

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2 1 5 1 - State Registrar Certificate of Death t's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month October 3:30 AM /Medical 2006 Examiner 4c. County of Death Altmore
or 1 Year | If Under 24 Hr Kepaba Nursny N/A 6. Sex **Funeral**  Birthplace (State or Foreign Country) 1 □ M 2 KF Months Days Hours Director Pennsylvania 10a. State 10b. County ehow 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f eho: traumatic event, itre M. of cal Examinar must be notified at Funeral Director 1 Yes 2 □ No N/A 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 1801 21227 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 XNo 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 Marned þ 1 ☐ Yes 2 ☑ No 3 Widowed 4 Divorced Specify: White Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit, Pages 1 and 2 should be filed within 72.
Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "na any Injury or other traumatic event, Ite M. of one. Elementary/Secondary (0-12) College (1-4or 5+) Executive / Counsellor Retail / Health 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Joseph Thomas Murphy Barbara Mary Knight 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sandra Murphy Schmidt, Sister 1621 Wilson Point Road Middle River, MD 21220 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 【ACremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc. 11/01/06 Baltimore, Maryland 21. Signature of Funeral Service Oceansee
Thomas Gregor <sup>22</sup> Name and Address of Facility
Cremation Society Of Maryland, Inc.
299 Frederick Road Baltimore, Maryland 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician ementia disease or condition resulting in death) -e avs /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 □ Fetal uea 4 □ Pregnant at time of death 2 Fetal death in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ voidism Completed 2 X No 3 Probably 4 □Unknown 1 Tyes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? 1 Yes 2 No 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ပ 1 ☐ Yes 2 No 1 🗌 Inpatient 2 ER/Outpatient 3 DOA this After the 28a. Date of Injury (Month, Day Year) 27. Manner of Death Certification: 28b. Time of Injury 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending death. investigation 1 ☐ Yes 2 ☐ No Director: , 6 Could not be determined 3 Suicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours aft To the Funeral Di completely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier

State Registrar 30. Name and address of person who comple in

Vi

31. Date filed (Frontin Day, Year)

DHMH 17 Rev 1/2001

Baltimore, Maryland

c. use of death (Item 23a) (Type, Print)

Senson

2006

32. Registrar's Signature

			riease	Type of Pilit					•	•
			1 For State	State of Mary		artment of lartificate of			4000	34829
			Registrar  1. Decedent's Name (First, Middle, La	251)		Tillicate of	Dealli	2. Date of De	Reg. No.	3. Time of Death
B	Physici /Medio	al	DAMAION	KARIM A	IWAC			Month	72 100	60632AM
*	Examin	er	4a. Facility Name (If not institution, gire	Re-			or Location of Dea		4c. County of De	
		.03	5. Social Security Number 6.		n yrs. last birthday	SILVE If Under 1 Year	R SPRI	N 6	MONTG	OMERY
Ė,	Funeral Director			1 <b>X</b> M 2□F	Yrs.	Months Days			5 2006 M	irthplace (State or Foreign Country)  ARYLAND
	show	or	10a. State 10b. County		Oc. City, Town or L					10d. Inside City Limits 1 XYes 2 □ No
	death with the Maryland ma 23a or 28a-f show rmust be notified at	Funeral Directo	10e. Street and Number	IRIS	COLL	10f. Zip Code			10g. Citizen of What 0	
	ath w	rail	5917 TAM		#6	3101			USA	
	tema tema	nue	11. Marital Status	12. Was Decedent Ever Armed Forces?	r in U.S. 13.	Was Decedent of If Yes, specify Cub	Hispanic Origin? ( ban, Mexican, Pue	Specify Yes or No rto Rican, etc.)	14. Race - An Black, Wh	nerican Indian, nite, etc.
3036	ural', or l	by	1 Never Married 2 Married 3 Widowed 4 Divorced	1 Tyes 2 No If Yes, Give Year or Dates:		1□Yes 2₩No	Specify:		Specify: $oldsymbol{\mathbb{Z}}$	LACK
Maryland 21215-0036	be filed within 72 hours after death with the Marylan tal Hygliene. d other than "natural", or Itema 23a or 28a-f show event, the Madical Experience must be notified at	Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)		(Give	edent's Usual Occu e kind of work done DO NOT use retire	during most of we	orking	16b. Kind of Busines	s/Industry
7	filed wi Hygien Sther th	Con		none	none				none	
ב	be fill d off	Be	17. Father's Name (First, Middle, Las.					3	, Maiden Sumame)	
3	should be and Menta marked umatic ev	2	KARIM A A					MELINE		
<u>a</u>	2 2 2 2		19a. Informant's Name/Relationship						er, City or Town, State,	
re,	Pages 1 and nent of Health int: If item 27 iry or other ti		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 [	Removal from State	20b. Place of Disp			Date SILV	20c. Location - City of	
Baltimore,	permit. Page Department of Important: If any Injury or once.		4 Donation 5 Other (Special Service) lice RONAL C		597	raneand Addu	rtohfy <sup>cili</sup> Boa	rd 655 W	. Baltimor	e Street
	4024G		23a. Part1. Inter the disease, J com	1 tille		baltimore		201		
Nemen	Physician **/Medical Examiner		shock, ir heart failure. List only Immediate Cause (Final disease or condition resulting in death)	in lications that caused the rone cause on each line.  a. Die to (or as a co	TURIS					Approximate Interval Between Onset and Death 3 kg 32mm
	Examiner	er	Sequentially list conditions, if any, Isauing to immediate	b. SEPS	n Sequence of):					
	be executed icien and buriat-transit	Examiner	if any, Isading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	U	XEWIA	\				
/60,	icate be executed physicien and s the burial-transit	cal E	Todaling III doditi / Eddi	Due to (or as a co		Y FAI	LURE			
9	ng ph as th	Med	IE CENALE.							
O. Box	at the death certificate by the attending phys lached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of p 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3	□Ectopic pregnand □ Other (specify) _	y		23d. Date of de Month	elivery Day Year
7.	het th ed by detac	Ph)	Part II. Other significant conditions	contribution to death but no	ot resulting in the I	inderlying cause or	ven in Part I	23e Did t	obacco use contribute	to the cause of death?
ords,	law requires thet the as been signed by th 2 should be detache	ted by						1 🗆 `		Probably 4 Unknown
Hecords,	o	Completed						24a. Was autop perfo 1 \sum Yes		
VITa	iclan: Th certificate rector, pag	Be	25. Was case referred to medical				26. Place of De	ath  Check only o		
> 0	d is	To	examiner? 1 ☐ Yes 2 No	Hospital: 1 Linpatient	2 ER/Outpatie	nt 3 DOA	her: 4 🗆 Nursing	Home 5 ☐ Resid	dence 6 □Other (Sp	ecify)
	<b>D e e e</b>		27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Ye	28b. Time of Injury	Wo	ry at vrk? ]Yes 2 □ No	28d. Describe I	now injury occurred	
DIVISION	tal or Attending s after death. at Director: After ed in by the fune	Certification:	3 Suicide 6 Could not to 4 Homicide determined	De Blace of Journ				28f. Location (S City or Tox	Street and Number or F wn, State)	Rural Route Number,
	Hospi 4 hour Funer tely fill	Medical (	29a. Certifier   Certifying Pl (Check only one) 2   Medical Exa	hysician: To the best of m miner: On the basis of exa and manner stated.	amination and/or ir	th occurred at the ti nvestigation, in my	me, date and plac opinion, death occ	e, and due to the curred at the time,	cause(s) and manner a date and place, and du	is stated. le to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	2 2		29c. Licen	se number		29d. Date signed (Mor	
			Tour Cla	te, M.D		200	31315		10-25-2	2006
			30. Name and address of person who	completed cause of death	(Item 23a) (Type	, Print)				*
			DITTION OF	ARTE 1500	O FORES	T GLEN	RD SIL	VER SPR	ING MD 2	0910
	Sta Registr		31. Date filed (Month, Day, Year)	32! Registrar's	Signature	well s				

DHMH 17 Rev 1/2001

06-08238 Ali Padder

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

		For State	Certificate of		and Michigan		g. No. 200	16.31.83
Physiciar Medical Examin	ш.	1. Decedent's Name (First, Middle,Last) Ali Padder				Date of Death     Month     October 31	Day Year	3. Time of Death
(		4a. Facility Name (if not institution, give street and number) Route 70 West at 3 mile exit	4	b. City, Town, Hancock	or Location of Death		4c. County of Dea Washington	th
Funeral Director		5. Social Security Number 6. Sex 7. Ag 1 X M 2 F	e (In yrs. last birthday) 4 Yrs.		Year If Under 24Hrs Days Hours Min	_	2001 9. B	
or items 23a or 28a-f show any must be notified at once.	Director	Usual Residence of Decedent 10a. State 10b. County MD Howard 10e. Street and Number 11026 Dorsch Farm Road	10c. City, Town or Locati Ellicott	City 10f. Zip Code	e 21042	10	g. Citizen of What Co USA	10d. Inside City Limits 1 Yes 2 X No untry?
36 in 72 hours afte nan "natural"; iteal Examine	Completed by Funeral	11. Marital Status 1 X Never Married 2 Married Armed Forces? 3 Widowed 4 Divorced If Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade con Elementary/Secondary (0-12) College (1-4 or state)	My No 1 1 16a. Deceden	es, specify Cul Yes 2 X t's Usual Occu ost of working	Hispanic Origin? ( Span, Mexican, Puerto No specify: pation (Give kind of life. DO NOT use reti	Rican, etc.)	White, etc.	
21215-0036 uld be filed within 7 Mental Hygiene, marked other than	Be Com	17. Father's Name (First, Middle, Last) Feroz A. Padder			18.Mother's Name		laiden Surname)	
MD 21 nd 2 should alth and Me m 27 is man aumatic ev		19a. Informant's Name/Relationship (Type, Print) Feroz A. Padder (Father)	11026	Dorsc	h Farm Roa	ad Ellic	ott City,	MD 21042
Baltimore, MD 21215-003 permit. Pages I and 2 should be filed with Department of Health and Mental Hygiene. Important: If viem 27 is marked other tinjury or other traumatic event, th. M. M.		20a. Method of Disposition  1 X Burial 2 Cremation 3 Removal from St.  4 Donation 5 Other Specify:  21. Signature of Funeral Service Licensee	Lake View	nerplace) 7 Mem P 1400 Published Auto	ark 11/3	Date 3/2006 E & CHAP 784 (410	Sykesvill EL, PA (Bc) -795-1400	e, MD
Physician /Medical Examiner	_	23a. Part I. Enter the disease, or complications that caused failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate  Due to (or as a constitution).  Due to (or as a constitution).	equence of):	ne mode of dyi	ng, such as cardiac d	or respiratory arre	st, shock, or heart	Approximate interval Between Onset and Death
ecuted and transit	Examine	Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  d.						
ox 68760,  arth certificate be exattending physician or use as the burial	hysician/	1 Yes 2 No 9 Unknown g Unknown	time of death 5 Oth	her (Specify)	3 Ectopic pregna		23d. Date of delive Month	Day Year
Division of Vital Records, P.O. tal or Attending Physician: The law requires that it is after death.  All Director: After this certificate has been signed by lied in by the funeral director, page 2 should be detactive.	Completed by F	Part II. Other significant conditions contributing to deat	h but not resulting in the u	inderlying caus	se given in Part I.		n 24b. Were a prior to death?	obably 4 Unknown autopsy findings available completion of cause of
Vital Rec	Be	25. Was case referred to medical examiner?  Hospital: 1 Inpatie	ent 2 ER/Outpatient		Other Nursin		Residence 6 🗸 Oth	or: Scene
on of Vit ending Physic ath. rr: After this he funeral dir.	tion: To	27. Manner of Death  Natural 5 Pending Oct 31, 2006	ıry 28b. Time of Ir		Injury at Work?  Yes 2 • No	28d. Describe h	ow injury occurred uto auto collision	
Division Hospital or Attend 24 hours after death. Funeral Director: rely filled in by the f	Certification:	Suicide Could not be determined (Specify) Inte	jury - At home, farm, stree erstate/Express	et, factory, offic	ce building, etc.	or Town, St	treet and Number or F ate) t @ 3 mile exit, Har	Rural Route Number, City
To the Hospital within 24 hours a To the Funeral I completely filled	edical	29a. Certifier 1 Certifying Physician: To the best of m Cheek only 2 Medical Examiner: On the basis of examiner and manner stated.		ion, in my opin	nion, death occurred a		and place, and due to t	the cause(s)
		29b. Signature and title of certifier  30. Name and address of person which completed cause of d	leath (Item 23a)		ense number C.M.E.		November 1, 20	
Q		Susan Hogan MD. Assistant Medical Example 1. Date filed (Month, Day, Year) 32. Registra	xaminer 111 Pen	n Street, B	altimore, MD 21	201		
Sta Registr	~	NOV 0 2 2006	a Signature	well o			<del>.</del>	

Please Type or Print in Black Indelible Ink 06-08237 State of Maryland / Department of Health and Mental Hygiene Ayesha Padder Certificate of Death 1- For State Reg. No Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month 1720 hrs Padder Medical Examiner Ayesha October 31, 2006 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Washington Hancock Route 70 West exit 3 If Under 1 Year | If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) 5. Social Security Number **Éuneral** oreign Country) Months Days Hours 09-05-1997 Director M 2X F 9 410-83-4397 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. Count Yes 2 X No s 23a or 28a-f show e notified at once. Ellicott City Howard MD permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygione. Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21042 11026 Dorsch Farm Road 14 Race - American Indian, Black Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No 11. Marital Status 12. Was Decedent Ever in U.S. or items? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 X Never Married 2 X No Yes Specify: Other Asian Yes 2 X No specify 4 Divorced If Yes, Give Year Widowed 127 is marked other than "natural", umatic event, the Medical Examiner ğ 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) Education Student Baltimore, MD 21215-0036 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Feroz A. Padder Amira Abbass 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print ) Important: If item 27 is injury or other traumatic 11026 Dorsch Farm Road Ellicott City, MD 21042 Feroz A. Padder, M.D. (Father) 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State Date crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Sykesville, MD Lake View Mem Park 11/3/2006 4 Donation 5 Other Specify: <sup>22</sup>HATCHIIAdreneERAL Sykesville, MD 21. Signature of Funeral Service Licensee HOME & CHAPEL, PA (Box 195) 21784 (410)-795-1400 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and failure. List only one cause on each tine Medical Death a. Multiple Injuries Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death

To the Funeral Director: After this continuation. Physician/Medical AMENDED UNPENDED ending physician use as the burial -#24a,perME, G862 12/5/06 TI 23c. If yes, outcome of pregnancy 23d. Date of delivery IF FEMALE: 23b. Was decedent pregnant in the 3 Ectopic pregnancy Live hirth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 V No 9 Unknown q Linknown 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. Part II. Other significant conditions þ 1 Yes 2 V No 3 Probably 4 Unknown Completed this certificate has been 24a Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? death? Tes 2 X No 1 🗸 Yes 2 No 26.Place of Death (Check only one) 25. Was case referred to medical Be Other<sub>4</sub> examiner? Hospital: 1 Nursing Home 5 Residence 6 ✔ Other: Scene Inpatient 2 FR/Outpatient 3 1 ✓ Yes No 2 28d. Describe how injury occurred 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death Certification: Passenger auto auto collision Oct 31, 2006 1716 hrs Natura Yes 2 V No neral Director: / filled in by the fi Pending 2 🗸 Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 Could not be Suicide or Town, State) I- 70 West exit 3, Hancock, MD determined (Specify) Interstate/Express 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started Medical 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signatu and little of certi November 1, 2006 O.C.M.F. 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Susan Hogan MD.

Registrar

DHMH 17 Rev 1/2001 **OCME 2006** 

31. Date filed (Month, Day, Year)

NOV A

9

32. Registrar's Signature

Amend #8 Per FH G861 11/02/06 JH Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month **Physician** 8:13PM 10 30 2006 Catherine Pope /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore City n/a 3711 Boarman Avenue ff Under 1 Year If Under 24 Hrs. 8. Date of Birth 1949
Months Days Hours Min. 01/12/1949 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months 1□ M 2X F Yrs 58 NY 216-54-5017 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10h. County 28a-f show the Medical Examiner must be notified at Baltimore City 1X Yes 2 No MD Director 10e. Street and Number 3711 Boarman Avenue 10g. Citizen of What Country? 10f. Zip Code ō 21215 USA 23a Funeral filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Itams 1 ☐ Never Married 2 ☐ Married ō Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: þ Black. 3 Widowed 4 □ Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education permit. Peges 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na eny injury or other traumatic event, the Medic 2006. (Specify only highest grade completed) Coflege (1-4or 5+) Elementary/Secondary (0-12) 12th laborer packing company 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Pearline Lawrence unknown 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Gelores T. Key / Daughter 3711 Boarman Avenue; Baltimore, MD 21215 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition
1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from State 20c. Location - City or Town, State 11/04/2006 King Memorial Park Randallstown, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Wylie Funeral Home, P.A. Hunerla 638 N. Gilmor Street; Baltimore, MD 21217 used the deat ( o not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that shock, or heart failure. List only one cause fmmediate Cause (Final disease or condition resulting in death) Pars **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner Hospital or Attanding Physicien: The law requires that the death certificate be executed signed by the attending physicien and be detached for use as the burial-transit resulting in death) Last Due to (or as a consequence of): of Vital Records, P.O. Box 68760, Certification; To Be Completed by Physician/Medical IF FEMALE: If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Year Day 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions gentributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2□No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 🗌 Yes 1 Yes 2 No within 24 hours efter death.

To the Funerel Director: After this certific completely filled in by the funeral director. 25. Was case referred to medical examiner?
1 Yes 20 No 26. Place of Death (Check only one) 4 Nursing Home 5 Residence 6 □Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Dealh 1 X Natural 2 ☐ Accident 28b. Time of Division 5 Pending 1 ☐ Yes 2 ☐ No investigation 28e. Place of friury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medicai Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29b. Signature and title of certifier 32 Registrar's Signature 31. Date filed (Month, Day, State Registrar

Anthony P. Roma		I- For State	State	e of Marylan		rtment o		d Mental		Reg No. 20	06	3483
Physiciar Medical Examin	1/	Registrar 1. Decedent's Nam Anth	ie (First, Middle,La	,					2. Date of De Month October 2	ath Dav Year	- 1	Time of Death
	ı	4a. Facility Name (		ve street and numb	ber)		4b. City, Town, or	Location of De		4c County of I		
Funeral	٩	<ol> <li>406 Linden</li> <li>Social Security I</li> </ol>		Sex 7	. Age (în yrs. la	ast birthday)	Cambridge  If Under 1 Year	r If Under 24	Hrs. 8. Date of B	Dorcheste		ice (State or Foreign
Director		084-38-4	.597 X	M 2 F		60 Yrs	Months Day	s Hours N	Sept.	20,1946	Country New	York
	ŀ	Usual Residence o	f Decedent 10b. County		110c City	Town or Locat	ion				110	d. Inside City Limits
how ar	_	Maryland	Dorches	ter	loc. Gity	Cambri					1	Yes 2 XNo
eath with the Maryland items 23a or 28a-f show any ust be notified at once.	$\sim$ L	10e. Street and Nu				Campi	10f. Zip Code			10g Citizen of What	Country?	
th the N 23a or notified		406 Lind	len Avenu				216			USA		
r death wii or items ? must be !	Funeral	<ul><li>11 Marital Status</li><li>1 Never Marri</li></ul>	ed 2 Marrie	12. Was Deced	ces?		is Decedent of His es, specify Cubar		(Specify Yes or N erto Rican, etc.)	o- 14. Race - A White, e		Indian, Black,
P 5 2 1	by Fu	3 Widowed	4 X Divorce	1 X Yes If Yes, Give Year or Dates	70 <b>-</b> 76	1 🗌	Yes 2 X No	specify		Specify	Whi	te
hours 'natur		15 Decedent's E		only highest grade College (1-4	1.5	16a. Deceder during m	nt's Usual Occupa lost of working life	tion (Give kind . DO NOT use	of work done retired)	16b Kind of Busin	ess/Indus	itry
336 thin 72 re than '	Completed	12	ondary (0-12)	College (1-4	10(3+)	Carpe	nter			Self En	ıplov	ed
		17. Father's Name		t)						Maiden Surname)	F	
2121 buld be fill Mental F marked ic event,	To Be	Anthony  19a. Informant's Na	Romano	Type, Print )	_	19b Mailin	g Address (Stree		ncy Regin	na Imber, City or Town,	State Zip	Code)
MD and 2 shoulth and m 27 is aumatic	_[	Linda_S	abatasso	, Sister		711 S	chool St	reet #1		in, NY 115		
or Heal		20a. Method of Dis 1 Burial 2		Removal from		Place of Dispos crematory or ot	sition (Name of ce her place)	metery,	Date	20c. Location - C	ty or Tow	n, State
altimore, mit Pages I ar partment of Hee portant: If ite ury or other tr		4 Donation 5	Other Specif	īv	Mei	tro Cre	matory I	nc. 11	1/02/06	Baltimor	e, M	aryland
Bal permi Depar Impo injur	ļ	Thomas G	regor	1/mm ~ )	Jan	_   ''C	remation	Societ	y Of Mar	ryland, Ir more Mar	c.	J 21228
Physician	1	23a Part I. Enter the failure List on	ne disease, or con	plications that cau	sed to death	Do not enter t	he mode of dying.	such as cardia	ic or respiratory ar	rest, shock, or heart	A <sub>f</sub>	pproximate Interval
/Medical Examiner		Immediate Cause or condition resulti		Due to (or as a co	is of the						-	Death
Same		Sequentially list co		Alcohol								
	iner	if any, leading to in cause Enter Under	erlying Cause	Due to (or as a c	onsequence o	f):						
nted d ansit	Examiner	(Disease or injury to events resulting in		Due to (or as a c	onsequence o	f).						
s0, te be executed ysician and burial - transit	edical	X UNPENDED	)	AMENDED #2	23a-b,27	perME,g8	61,11/8/06	TT				
6876( certificate rding phys	m/M	IF FEMALE. 23b. Was decedent		23c. If yes, ou	itcome of preg	nancy	etal death 3	Ectopic pre	gnancy	23d Date of de Month	livery Day	Year
Box 6876: e death certificate the attending phy ed for use as the b	sician/M	past 12 months	s? No 9 ☐ Unknov		nt at time of de	-44	her (Specify)					
of Vital Records, P.O. Box 6876 ing Physician: The law requires that the death certificate After this certificate has been signed by the attending phytimeral director, page 2 should be detached for use as the control of the control of the detached for use as the control of the detached for		Part II. Other sign				esulting in the i	underlying cause	given in Part I	23e. Did	tobacco use contribu	te to the c	ause of death?
Records, P.O. I The law requires that the cate has been signed by the page 2 should be detached.	g ps							_	_ 1 Ye	es 2 <b>V</b> No 3	Probably	4 Unknown
of Vital Records, mg Physician: The law requir Miter this certificate has been s meral director, page 2 should	ompleted							- <del></del>	24a Was		r to comp	y findings available letion of cause of
Rec The l	ပေး	25.111							1 🗸 Yes		Yes	2 No
/ital	o Be	25. Was case referexaminer?  1 ✓ Yes	2 No	Hospital: 1 Inp	patient 2	ER/Outpatient		Other Nu	rsing Home 5	Residence 6	Other Sca	ene
Ing Ph	uo Liuo	27 Manner of Dea	th	28a. Date of (Month, D	Injury Day,Year)	28b. Time of I		ry at Work?	28d Describe	how injury occurred		
Division tal or Attendi rs after death al Director: A led in by the fu	catio	2 Accident	5 Pending Investiga		of Injury At h	amo form etro	et, factory, office l	Yes 2 No	20f Location	(Street and Number of	- D   D	(a. ta Aliverbas Oct
Divi	ertificati	3 Suicide 4 Homicide	6 Could no determin	ot be	or injury - At h	ome, iaim, sie	et, lactory, office t	building, etc.	or Town,		ir Rurai R	oute Number, City
Sp Parity Sp Par	Medical C	29a Certifier 1		er:On the basis of	examination a					ise(s) and manner as and place, and due		ısə(s)
F 3 F 8	Me	29b Signature/and	title of certifier	and manner sta	1		29c. Licens			29d Date signed	(Month, [	Jay. Year)
		XIC	W	1	/		O.C.	M.E.		October 25, 2	2006	
		30. Name and add Susan Hog	·	content ded cause sistant Medica			n Street, Bal	timore, MD	21201			
Sta Registr	te	31. Date filed (Mor	oth, Day, Year)	06 <sup>32</sup> Regi	istrar's Signat	P Ass	The same of the sa					
09.0			J			•						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month OCTOBER Year **Physician** SCHMIDTI MARY 12:50 PM ZOOC /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner HOSPITAL RANDAUSTOWN NORTHWEST Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Feb. 25, 1935 7. Age (In yrs. last birthday, 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** 1 □ M **X**XF Days Hours Min 71 Pennsylvania Director 166-26-8609 Usual Residence of Decedent death with the Maryland r 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Baltimore 1 Yes X No Director Reisterstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or edical Examiner must be r 302 Cantata Ct. Apt. 310 21136 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes XXNo If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene. ant! If item 27 is marked other than "natural", or ite ury or other traumatic event, the Medical Examine ury or other traumatic event, the Medical Examine. 1 Never Married XX Married 1 ☐ Yes XX No Specify: Baltimore, Maryland 21215-0036 Specify: White þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Health Elementary/Secondary (0-12) College (1-4or 5+) Physician's Assistant Care 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Edward Robare Margaret Shannon 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21136 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2: Department of Health a Important: If Item 27 is any injury or other trau Raymond W. Schmidt / Husband 302 Cantata Ct. Apt. 310 Reisterstown, MD 20b. Place of Disposition (Name of cemetery, crematory, or other place)
Lakeview
Memorial Park 20a. Method of Disposition Date 20c. Location - City or Town, State XXBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11/3/06 Sykesville, MD 21. Signature of Frn, al Savice Licenses 22. Name and Address of Facility Eckhardt Funeral Chapel P.A. 11605 Reisterstown Rd. Owings Mills, MD21117 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) TOGENIC RRHOSIS Physician /Medical sequence of) **Examiner** Sequentially list conditions, Examiner Due to (or as a consequence of) It any, leading to immedicause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last requires that the death certificate be executed attending physician and for use as the buriaf-trar Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 Probably 4 ☐ Unknown Completed 24a. Was an autopsy performed? 1□ Yes 2△□No 24b. Were autopsy findings available prior to completion of cause of death? 2 **X**No To the Hospital or Attending Physician; 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 1 ☐ Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3□ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After (Month, Day Year) 1 Natural Injury 5 ☐ Pending М 1 ☐ Yes 2 ☐ No investigation s after death 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours at To the Funeral Completely filled i Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 054352 OCTOBER 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MIRCEA TODOR MOSPITAL NORTH WEST Shot OLD COURT ROAD REANDALISTOWN MD 21133 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Grandy NOV 0 2 2006 Registrar

DHMH 17 Rev 1/2001

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Registrar

NOV 0 2 2006

		4	For State Registrar	State of Mary		artment of H tificate of I			ene∕ UU6 g. №.	34836
	Physicia	200	1. Decedent's Name (First, Middle, Last		TD			2. Date of Death	Day Year	3. Time of Death
	/Medic Examin	al	SHIRLEY PARKE  4a. Facility Name (If not institution, give		JR.	4b. City, Town, or	r Location of Death	001. 30	4c. County of Dea	10:00p M
	Examin	23	21299 DUNK FREE	CLAND ROAD		PARKTO	N If Under 24 Hrs.	La David (Birth	BALTIN	
	Funeral Director		5. Social Security Number 6. Se 217-50-0427	x 7. Age (In 2 M 2 □ F 6 2	yrs. last birthday) Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birth Month, Pay 9 / 2 4 / 1 9	Year) 9. Bir 044 MAI	thplace (State or Foreign ountry) RYLAND
45	Ö		Usual Residence of Decedent  10a. State 10b. County	10	c. City, Town or Lo	cation				10d. Inside City Limits
	Maryla	tor	MD BALTIMO	RE F	PARKTON					1 ☐ Yes 2 ☐ 📉 o
	with the 3a or 28a I be not	i Director	10e. Street and Number 21299 DUNK FREE	CLAND ROAD	)	10f. Zip Code	21120	10	og. Citizen of What C USA	ountry?
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: if Item 27 is marked other than "natural", or Itema 23a or 28a-f ehow empty injury or other traumatic event, the Medical Examinar must be notified at angle.	by Funerai	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever Armed Forces? 1Yes 2 XNo If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 21 No	lispanic Origin? (Sp an, Mexican, Puerto Specify:	pecify Yes or No- p Rican, etc.)	14. Race - Am Black, Whi	te, etc.
2-0	72 ho	eted	15. Decedent's Edi (Specify only highest grad	ucation de completed)	16a. Dece (Give	dent's Usual Occup	ation during most of work d)	king	6b. Kind of Business	/Industry
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Maryland	should nd Men marke imatic	으	SHIRLEY PARKER  19a. Informant's Name/Relationship (7)		19b. Mailir	ng Address (Street		CURTIS	City or Town, State,	Zip Code)
	and 2 :saith ar	i	DREW BURGESS	cousi		and the second	FREELAN			MD 21120
Baltimore,	Pages 1 nent of He ant: If Iter ury or oth		20a. Method of Disposition 1 ☐ Burial 2 ACremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State	20b. Place of Dispo cemetery, crei REEN MC	matory or other place DUNT		/2006 H	ROC. Location - City of BALTIMORI	E, MD
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	/Medical Examiner		resulting in death)	Due to (or as a co	onsequence of):					
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Box 6	that the death certific led by the attending p detached for use as	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 Ho 9  Unknown	23c. If yes, outcome of p 1□Live birth 2 [ 4□ Pregnant at tim 9□ Unknown	Fetal death 3	_Ectopic pregnanc _ Other (specify) _	у		23d. Date of de Month	blivery Day Year
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of V	S 25	2	examiner? 1 Tes 22 No  27. Manner of Death	Hospital: 1 Inpatient	2 ER/Outpatie	nt 3L DOA			once 6 Other (Sp	ecify)
lo	ding h. After funer	ation	1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Y	ear) Injury	Wo	rk? ]Yes 2 □No		,- ,	
Division	Il or Attendi after death I Director; A d in by the f	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc. (	- At home, farm, st 'Specify)	reet, factory, office		28f. Location (St City or Town	reet and Number or F i, State)	Rural Route Number,
	To the Hospital or Atta within 24 hours after de To the Funeral Directo completely filled in by th	ledical C	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	ysician: To the best of r niner: On the basis of ex and manner states	camination and/or in	th occurred at the tinvestigation, in my	ime, date and place opinion, death occu	, and due to the coursed at the time, d	ause(s) and manner a ate and place, and di	as stated. se to the cause(s)
	To the within To the comp	Me	29b. Signature and title of certifier	mo.		- 22	se number		9d. Date signed (Mor 10 - 31 - 06	
	7		30. Name and address of person who	completed sause of deal	h (Item 23a) (Type	_	1321 Vally m			
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**ORIGINAL** 

			State of Maryla		artment of artificate of			ienę () eg. No.	06 3	34837
		1. Decedent's Name (First, Middle, L	ast)				2. Date of Deat	th		Time of Death
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Exami		4a. Facility Name (If not institution, g	ive street and number)	0			or Location of Death	4c. County	of Death	
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Funeral		5. Social Security Number unk 6.	1177 M 2 □ E	vrs. last birthday)  Yrs.	If Under 1 Year Months Days		in. (Month, Day,		<ol> <li>Birthplace Country)</li> </ol>	(State or Foreign
Director		Usual Residence of Decedent	59	9			Jan 7,	1947		
yland		10a. State 10b. County	10c.	City, Town or Lo	cation				10d. li	nside City Limits
Mar a-fs	to	MD Allegan	У	Cumber	Land				1	□Yes 2√□No
ि के 10 कि	Director	10e. Street and Number			10f. Zip Code		1	0g. Citizen of V	What Country?	
filed within 72 hours after death with the Maryland Hygiene. Thygiene. Ther than "neturel", or Items 23a or 28a-f show ont, the Medical Evaminer must be notified at	rai	13800 McMullen H				21502		US	A	
er de	Funeral	11. Marital Status unk	12. Was Decedent Ever in Armed Forces?	n U,S. 13.	Was Decedent of f Yes, specify Cub	Hispanic Origin? can, Mexican, Pu	(Specify Yes or No- erto Rican, etc.)		e - American In	dian,
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ding f th. After funer	to	Natural 5 Pending 2 Accident investigation	(Month, Day Year)	) Injury	28c. Inju Wo M 1	rk? ]Yes 2∐No		,,	-	
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ol or effe	le I	4 Homicide	building, etc. (Spe	ecify)			City or Town	, State)		
To the Hospitel or Attendi within 24 hours efter death To the Funerel Director: A completely filled in by the f	edical C	29a. Certifier (Check only one)  Certifying P Medical Exa	hysician: To the best of my k miner: On the basis of exami and manner stated.	nowledge, death ination and/or inv	occurred at the ti estigation, in my	me, date and place opinion, death oc	ce, and due to the ca curred at the time, da	use(s) and ma ite and place, a	nner as stated. and due to the o	cause(s)
To th withir To th	M	29b. Signature and title of certifier	M mass	A .	29c. Licens	se number	29	d. Date signed	(Month, Day,	Year)
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Exam		4a. Facility Name (If not institution, give	street and number)	4b. City, Town, or	r Location of Death		4c. County of De	
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Funera	1	5. Social Security Number 6. Se	7. Age (In yrs. last bit	rthday) If Under 1 Year	If Under 24 Hrs.	8. Date of Birth (Month, Day, Ye	9. B	irthplace (State or Foreign
Directo		296-07-3679	X <sup>M 2□F</sup> 85	Yrs. Months Days	Hours Min.	Nov 27 19	920 P	Country) .
D.		Usual Residence of Decedent				1101 27 2		
irylar show	_	10a. State 10b. County Md Carroll	10c. City, Tow	m or Location lersburg				10d. Inside City Limits
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ine, intally lated A. I.A. 10-0000 s 1 and 2 should be filed within 72 hours after deeth with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "naturet", or items 23a or 28a-f show other traumstic event, the Medical Examinar must be notified at	by Funeral Director	10e. Street and Number	1d Ant D	10f. Zip Code		10g.	Citizen of What (	Country?
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er de	al n	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of H If Yes, specify Cuba	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - An Black, Wh	
s aft	<u>ک</u> ۲	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☑ Yes 2 □ No 1942- If ¥es, Give Year or Dates: 1945	1 ☐ Yes 2 🕅 No	Specify:		Specify: W	hite
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should Mari	-	19a. Informant's Name/Relationship (7	iype, Print) 19b	o. Mailing Address (Street	and Number or Rur	al Route Number Ci	tv or Town State	Zin Code)
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Head item		20a. Method of Disposition	20b. Place o	f Disposition (Name of		Date 20c	. Location - City of	or Town, State
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the d	yslc	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown	5 Other (specify)				,
thet t	0	Part II. Other significant conditions co	entributing to death but not resulting i	n the underlying cause give	en in Part I	23e Did tobacc	o use contribute	to the cause of death?
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hysi this c	은	TO THE ZORUNO		utpatient 3 DOA	- Industry no	me 5 Residence	6 □Other (Sp	ecify)
ing F	Certification:	27. Manner of Death  1 Natural 5 Pending		Time of 28c. Injury Work		28d. Describe how in	njury occurred	
tend leath lor: /	Cat	2 Accident investigation 3 Suicide 6 Could not be		M 1 []	Yes 2 □No			
or At ther d tirect n by	E	4 Homicide determined	28e. Place of Injury - At home, fa building, etc. (Specify)	arm, street, factory, office		28f. Location (Street City or Town, St	t and Number or I tate)	Rural Route Number,
ital o								
To the Hospital or Attending Physician: The law requires thet the death certificate be executed within 24 hours efter death.  To the Funarei Director: After this certificate has been signed by the ettending physicien and completely filled in by the funeral director, page 2 should be deteched for use as the burial-transit	edical	(Check only 2 Medical Exam	vsician: To the best of my knowledge iner: On the basis of examination are	e, death occurred at the timed or investigation, in my or	ne, date and place, pinion, death occur	and due to the cause ed at the time, date	e(s) and manner a and place, and di	as stated.
hin 2 the mplet	Med	Sile)	and manner stated.					
T with So	-	29b. Signature and title of certifier	MI	29c. License			Date signed (Mor	
:0			(/ 10	ני	54352	No	SVEMBE	R 1 2006
10		30. Name and address of person who o		(Type, Print) M	IRCEA	TODOR		
			OSPITAL SHOL OF	LA COURT RE	AND, RA	NDALISTO	WW, it	1D 21133
S Regis	tate	31. Date filed (Month, Day, Year)  NOV 0 2	32. Registrar's Signature	& South				
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Please Type or Print in Black Indelible Ink

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Dorothy Louis Willia	ams S	tate of Maryla		artment of rtificate of		nd Ment	al Hygiene		2.0	<b>n</b> n /	0100
Physician/	Registrar  1. Oecedent's Name (First, Mid-	dle,Last)		tinoate or	Douin		2. Date	Reg. N of Oeath	-	3.	Time of Death
Medical Examiner		OUIS WILLI	AMS				Monti Octo	oa ber 31, 2	y Year 2006	.	1059 hrs
	4a. Facility Name (if not institut 2010 Boone Street	ion, give street and nu	mber)	4	Baltimore	or Location o	f Oeath		4c. County of	Oeath  /A	
Funeral	5. Social Security Number	6. Sex	7. Age (In yrs. I	ast birthday)	If Under 1 Ye			e of Birth(N	M/OO/YYYY)		lace (State or
Director	217-60-2014	1_M 2XF	8	5 Yrs	Months Oa	ys Hours		02/19		Count	MARYLAND
any	Usual Residence of Decedent  10a. State 10b. County	,	10c. City.	Town or Locati	on						0d. Inside City Limits
<b>\$</b>	MARYLAND N/		,		BALTIMO	ਸੋਰ				1	X Yes 2 No
the Maryland a or 28a-f sh tiffed at once	10e. Street and Number				10f. Zip Code	1(1)		10g. (	Citizen of Wha	t Country	ſ?
Sa or 2	2010 BOONE	STREET			212	18			U.S.A.		
or death with the Maryland or items 23a or 28a-f show thust be notified at once.	11. Mantal Status  1 Never Married 2 XI		edent Ever in U prces?	.S. 13. Wa	s Decedent of H es, specify Cuba	lispanic Orig an, Mexican,	in? (Specify Ye Puerto Rican, e	s or No- tc.)	14. Race - White,		n Indian, Black,
er dea		1 Yes	2 X No	1	Yes 2 X N	lo specify:			Specify:	BT.AC	K
ntinral" amine	15 Decedent's Education (Co	or Dates:			t's Usual Occup	ation (Give k	kind of work done	e 16	b. Kind of Busi		
OO36 within 72 hour giene. her than "natu her than antu one Medical Exar	Elementary/Secondary (0-12	College (1	l-4 or 5+)	gunng m	ost of working lit	re. OU NOT	use retired)				
5-0036 led within 7 Hygiene. other than the Medica	8th grade 17. Father's Name (First, Middl	e last\		CAR	E PROVI		EAMTRESS s Name (First, M		HEAL'	TH	
215- be filed ntal Hygerked out	WILLIAM MC						ORENCE	nooro, mara	on comono,		
ould by Men is mar tic eve	19a. Informant's Name/Relation			19b. Mailing	Address (Stre		ber or Rural Rou	ute Number	, City or Town,	State, Z	ip Code)
MD and 2 sho alth and 2 is 27 is raumati	Nannett Turne: 20a. Method of Disposition	r/Daughter			Boone_		Baltimor Date		ryland		
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	1 XXBurial 2 Cremati	on 3 Removal fr	om State	crematory or otl	ner place)					•	
Itim it. Parantmen ortant ry or o	4 Donation 5 Other		K		ORIAL P.		11-06-0				MARYLAND
Depr. Depr. Inju	Markage (	/1		112	06 W NO:	RTH AV					E P.A.
Physician	23a. Part I. Enter the disease, of failure. List only one cause	complications that cose on each line.	aused the death	. Oo not enter t	ne mode of dyin	g, such as ca	ardiac or respira	tory arrest,	shock, or hear	t	Approximate Interval Between Onset and
/Medical /	Immediate Cause (Final disease or condition resulting in death)		rotic Cardiov		ease					$\rightarrow$	Death
	Sequentially list conditions,	b	consequence	n).							
iner	if any, leading to immediate cause. Enter Underlying Caus	e	consequence of	of):							
ted Insit Examiner	(Disease or injury that initiated events resulting in death) Last		consequence of	of):							
O, e be executed systeian and burial - transit ledical Ex:	UNPENDED	dAMENDED	_		<del></del>						
60, ate be o hysicia e buria			outcome of preg	nancy					23d. Oate of d	elivery	
Sox 6876C leath certificate c attending phys for use as the b	23b. Was decedent pregnant in past 12 months?	the 1 Live t		2 Fe	tal death 3	Ectopic	pregnancy		Month	Oay	y Year
Box (e death or the attended for use hysici	1 Yes 2 V No 9 U	nknown 9 Unkn		5 Ot	her (Specify)			_			
O. o. o. o. o. o. o. o. o. o. o. o. o. o.		litions contributing to	o death but not r	esulting in the t	inderlying cause	e given in Pa	rt I. 23e			_	e cause of death?
S, P uires the uires the signer lid be did be deb							_   1	Yes 2			oly 4  Unknown  psy findings available
of Vital Records, ng Physician: The law require. Wher this certificate has been signeral director, page 2 should b. n: To Be Completed	ß							autopsy performe	pri		npletion of cause of
Vital Recystrian: The Inis certificate Idirector, page		<del> </del>			00 DI-	+f D+h	(Charles and 1	Yes 2 ✔	No 1	Yes	2 No
/ital sician: is certi lirector	25. Was case referred to media examiner?	Manufal: (	Inpatient 2	ER/Outpatient		Other	(Check only one Nursing Home		sidence 6 🗸	Other: S	Scene
of Vital Recing Physician: The After this certificate Unertal director, page on: To Be Con	1 Yes 2 No 27. Manner of Oeath	28a. Date		28b. Time of I		ijury at Work	? 28d. De	escribe how	injury occurred	d	
ion trendir leath. tor: A	1 Natural 5 Pe	nding restigation	, <b>Da</b> y, rour,		1	Yes 2	No				
Division o tital or Attending urs after death. ral Director: After the director of the directo	3 Suicide 6 Co	ould not be 28e. Place	e of Injury - At h	ome, farm, stre	et, factory, office	e building, et		cation (Stre Town, State		or Rural	Route Number, City
Divisior Divisior Thospital or Attend 24 hours after death Finneral Director: seley filled in by the 1	29a Certifier	Physician: To the bes		lge death occur	red at the time	date and pla	ace and due to t	he cause(s	) and manner a	as starter	
Division of Vital I  To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certificampletely filled in by the funeral director, Medical Certification: To Be (	(Check only one) 2 Medical Ex	caminer: On the basis and manner s	of examination a	-							
Me Fare	29b. Signature and title of certi		0.0			nse number			d. Oate signed		n, Day, Year)
	tatuf bron	nica-tol	let w	·	0.0	C.M.E.		C	October 31,	2006	
51	30. Name and address of person Patricia Aronica-Poll	·	se of death (Iten ant Medical		111 Penn 9	Street. Ba	iltimore, MD	21201			
State		r) 32. Re	egiştrar's Signati		4					<u>-</u> -	
Registra	LIOU.	2 2000	Delas.	All Asi	sante!						

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiege Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Death Woodson Month Dev **Physician** Ellouise Oct 6:30 Am 2006 30 /Medical 4c. County of Death 4a Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Deeth Examiner Baltimore If Under 24 Hrs. 8. Dat Johns Hopkins
5. Social Security Number 6. Sec If Under 1 Year 7. Age (In yrs. lest birthdey) 8. Date of Birth (Month, Dev. Year) Birthplace (State or Foreign Country) **Funeral** Days Min. Months Hours 1 M 2 F Yrs. Director 919-99-3103 Usuel Residence of Decedent filed within 72 hours efter deeth with the Meryland 10a. State 10b. County NIA 10c. City, Town or Location r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 10d. Inside City Limits 1 Yes 2 No Directo Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 1512 street Funeral USA 14. Race - American Indian, 21213 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never-Married 2 Married 1 ☐ Yes 2 If Yes, Give 2 10 No Saitimore, Maryland 21215-0036 1 Yes 2 No Specify: ٥ 3 Widowed 4 □ Divorced Year or Dates Black Completed 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondery (0-12) College (1-4or 5+) 12 th Domestic Domestic ie merked other 17. Father's Neme (First, Middle, Lest) 18. Mother's Name (First, Middle, Maiden Sumame) Be Peges 1 end 2 should be 1 nent of Heelth end Mentel I John Bonds Gertrude Bonds 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) Depertment of Heelth important: If item 27 1 daughter Oise 3804 E. Jefferson St. Balto Or Prelo MD 21205 or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 ☐ Cremetion 3 ☐ Removal from State 6 | Owings Mills, MD Funeral Home 4 ☐ Donetion 5 ☐ Other (Specify) 11-80% torest zurrisch 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Betts Approximate Interval Between Onset end Death arrico 1129 N. Caroling Street Baltimore 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Physician Immediate Ceuse (Final disease or condition resulting in death) /Medical Jeans Ea Colon Examiner Due to (or es e consequence of) Examiner No Due Hyperturian The lew requires that the deeth certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due (or es e consequence of): Division of Vital Records, P.O. Box 68760, ettending physicien for use es the burie Physician/Medical Due to (or as e consequence of): ed by the detected Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably Anknown 1 ☐ Yes 2 ☐ No been signed be detected 2 24b. Were autopsy findings available prior to completion of cause of deeth? Completed 24a. Wes an autopsy hes certificate 1 ☐ Yes 2 No 1 ☐ Yes 2 No Physician: director, 25. Wes case referred to medical exeminer? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Yes 2 No 2 ER/Outpetient 3 DOA 4 hours after deeth.

\*\*uneral Director: After this ely filled in by the funerel di this 27. Manner of Death 28e. Dete of Injury (Month, Dey Year) 28b. Time of Injury 28d. Describe how injury occurred Certification: or Attending 1 Naturel 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 I Homicide Hospital within 24 hours a To the Funeral C 29a, Certifier Leg Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, and due to the cause(s) and manner as steted.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and menner steted. Medical 29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D 57088 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

Than from 201 ST. Foul Race Baltimere, mi) # 701 31. Date filed (Month, Day, Year) 32. Registrer's Signature State NOV 0 2 2006

DHMH 16 Rev 6/95

Registrar

Physician /Medical Examiner  1. Decedent's Name (First, Middle, Last)  GLADYS RUTH WEBSTER  4a. Facility Name (If not institution, give street and number)  LORIEN © RIVERSIDE  Funeral Director  1. Decedent's Name (First, Middle, Last)  GLADYS RUTH WEBSTER  4b. City, Town, or Location of Death  BELCAMP  5. Social Security Number  2. Date of Death  Month  OCT  ABELCAMP  5. Social Security Number  2. Social Security Number  1. Decedent's Name (First, Middle, Last)  4b. City, Town, or Location of Death  BELCAMP  5. Social Security Number  2. Bale of Birth (Month, Day, Y)  Months Days Hours Min.  JAN 31 1	ene 006	34841
Physician //Medical Examiner  GLADYS RUTH WEBSTER  4a. Facility Name (If not institution, give street and number)  LORIEN © RIVERSIDE  Funeral Director  Director  GLADYS RUTH WEBSTER  4b. City, Town, or Location of Death  BELCAMP  7. Age (In yrs. last birthday)  1		04041
A. Facility Name (If not institution, give street and number)   4b. City, Town, or Location of Death	Day Year	3. Time of Death
Funeral Director  LORIEN © RIVERSIDE  S. Social Security Number  1 M 2 M F  1 M 2 M F  82 Yrs.  BELCAMP  If Under 1 Year If Under 24 Hrs. Months Days Hours Min. JAN 31 1	4c. County of Death	5:10PM
Tuneral Director 218-22-7038 1□M 2⊠F 82 Yrs. Months Days Hours Min. (Month, Day, Y JAN 31 1	HARFO	RD
Director   218-22-7038   82   15.   JAN 31 1	9 Rinthol	ace (State or Foreign
Osdal riesidelice di Decedelit		YLAND
	10	Od. Inside City Limits
MARYLAND HARFORD CO EDGEWOOD		1 ☐ Yes 2 ☑ No
MARYLAND HARFORD CO EDGEWOOD  10e. Street and Number 10f. Zip Code 10g	. Citizen of What Count	try?
642 BURLINGTON CT. 21040  11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-	U.S.A.	an Indian
The control of the	Black, White, e	ntc.
86 3 3 TWidowed 4 □ Divorced If Yes, Give 1 □ Yes 2 No Specify:	Specify: BLAC	CK
TOO 100. State   10b. County   10c. City, Town or Location   10c. City   10c.	b. Kind of Business/Ind	ustry
College (1-4or 5+)  Elementary/Secondary (0-12)  Sth grade  FOOD SERVICE	WHITE STAF	S STIANT
N p shape T p p p p p p p p p p p p p p p p p p		11(021111
The property of the property o	LIAMS	
10a. State   10b. County   10c. City, Town or Location   10c. City, Town or Location   10d. Zip Code   10d.		Code)
Patricia A. Campbell/Daughter 642 Burlington Ct., Edgewood, 20a, Method of Disposition 20b, Place of Disposition (Name of Date 20	Md. 21040 c. Location - City or Tov	wn, State
Cemetery, crematory or other place)    Company   Compa		
21. Signature of Funeral Service Licensies 22. Name and Address of Facility	DDLE RIVER,	
WM C BROWN COMM FUNERAL HOM 321 S PHILADELPHIA BLVD.,	EBERBEERD, M	B·21001
Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, it any, feeding to inititediate cause. Enter Underlying Cause. (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or a consequence of):  Due to (or a consequence of):	v duslas	Onset and Death
Ifficate be e through graphysician as the buring as the bu		
d.  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown  23c. If yes, outcome of pregnancy 1   Yes 2   No 9   Unknown  23c. If yes, outcome of pregnancy 1   Live birth 2   Fetal death 4   Pregnant at time of death 9   Unknown  23c. If yes, outcome of pregnancy 1   Live birth 2   Fetal death 4   Pregnant at time of death 9   Unknown  23c. If yes, outcome of pregnancy 1   Unknown  23c. If yes, outcome of pregnancy 1   Unknown 23c. If yes, outco	23d. Date of deliver	y Day Year
. b ob 1 Yes 2 No		
The table of the part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobar	cco use contribute to the	e cause of death?
D 1 Yes	24b. Were autop	ev findinge available
1   Yes	d2 death?	pletion of cause of
24a. Was an aute has been an aute has be	]No 1 ☐ Yes :	
		2□ No
	ce 6 ☐Other (Specify,	2□ No
	ce 6 ☐Other (Specify,	2□ No
25. Was case referred to medical examiner?  1 Yes 2 No  25. Was case referred to medical examiner?  1 Yes 2 No  26. Place of Death (Check only one)  1 No  27. Mann of Death  28. Date of Injury  (Month, Day Year)  28. Date of Injury  Work?  M 1 Yes 2 No  28. Date of Injury  Work?  M 1 Yes 2 No  28. Date of Injury  Work?  M 1 Yes 2 No  28. Date of Injury  Work?  M 1 Yes 2 No  28. Date of Injury  Work?  M 1 Yes 2 No  28. Date of Injury  Work?  M 28. Date of Injury  Work?  M 1 Yes 2 No  28. Place of Injury  Work?  M 1 Yes 2 No  28. Date of Injury  Work?  M 1 Yes 2 No  28. Place of Injury  Work?  M 1 Yes 2 No  28. Place of Injury  Work?  M 1 Yes 2 No  28. Place of Injury  Work?  M 1 Yes 2 No  28. Place of Injury  Work?  M 1 Yes 2 No  28. Place of Injury  Work?  M 1 Yes 2 No  28. Place of Injury  Work?  M 1 Yes 2 No  28. Place of Injury  Work?  M 1 Yes 2 No  28. Place of Injury  Work?  M 1 Yes 2 No  28. Place of Injury  Work?  Work?  M 1 Yes 2 No  28. Place of Injury  Work?  M 1 Yes 2 No  28. Place of Injury  Work?	ce 6 Other (Specify, injury occurred	2 □ No
25. Was case referred to medical examiner?  1 Yes 2 No  25. Was case referred to medical examiner?  1 Yes 2 No  26. Place of Death (Check only one)  1 No  27. Mann of Death  28. Date of Injury  (Month, Day Year)  28. Date of Injury  Work?  M 1 Yes 2 No  28. Date of Injury  Work?  M 1 Yes 2 No  28. Date of Injury  Work?  M 1 Yes 2 No  28. Date of Injury  Work?  M 1 Yes 2 No  28. Date of Injury  Work?  M 1 Yes 2 No  28. Date of Injury  Work?  M 28. Date of Injury  Work?  M 1 Yes 2 No  28. Place of Injury  Work?  M 1 Yes 2 No  28. Date of Injury  Work?  M 1 Yes 2 No  28. Place of Injury  Work?  M 1 Yes 2 No  28. Place of Injury  Work?  M 1 Yes 2 No  28. Place of Injury  Work?  M 1 Yes 2 No  28. Place of Injury  Work?  M 1 Yes 2 No  28. Place of Injury  Work?  M 1 Yes 2 No  28. Place of Injury  Work?  M 1 Yes 2 No  28. Place of Injury  Work?  M 1 Yes 2 No  28. Place of Injury  Work?  M 1 Yes 2 No  28. Place of Injury  Work?  Work?  M 1 Yes 2 No  28. Place of Injury  Work?  M 1 Yes 2 No  28. Place of Injury  Work?	ce 6 □Other (Specify, injury occurred  et and Number or Rural State)  se(s) and manner as state and place, and due to	Poute Number,  atted. the cause(s)
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25. Was case referred to medical examiner?  26. Place of Death (Check only one)  27. Manny of Death (Month, Day Year)  28. Date of Injury of Injur	ce 6 □Other (Specify, injury occurred  et and Number or Rural State)  se(s) and manner as state and place, and due to	Poute Number,  atted. the cause(s)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] [] [ 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death\_ Month Year **Physician** WIESSNER Ernest 11.40 M Octo be 30 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Ellicott City Health & Rehab Howard Ellicott City If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 11√2 M 2□ F 80 219-10-2053 Yrs. Director Dec Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Md Howard Ellicott City 1 ☐ Yes 2 X No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŬSA 21043 8913 Old Frederick Road Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 √ Yes 2 No WWII If Yes, Give Year or Dates: 1 Never Married 20 Married Specify: White 1 ☐ Yes 2 X No Specify: 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) accounts receivable supervisor General Motors 18. Mother's Name (First, Middle, Maiden Sumame) Florence Alberta Forman 17. Father's Name (First, Middle, Last) Be Ernest Bernard Wiessner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8913 Old Frederick Rd., Ellicott City, MD 21043 Doris L. Wiessner (spouse) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of H Importent: If Ite any Injury or ot 20026. 1 Burial 2 Cremation 3 Removal from State Meadowridge Memorial 11-3-06 Elkridge, MD 1 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Haight Funeral Home & Chapel 21. Signature of Funeral Service Licensee Daige Haught Sterbert P.O. Eox 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Adenocarcinoma of Lung Immediate Cause (Final Metastalic **Physician** disease or condition resulting in death) /Medical Dhstrictue Long Discove Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated exercises) Examiner that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetaf death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 2.2 No 1 Yes 2 \( \text{No.} Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No 2 Accident investigation 6 Could not be determined 28e. Place of fnjury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

1)30641

29d. Date signed (Month, Day, Year)

The law requires that the death certificate be executed use as the burial-transit Division of Vital Records, P.O. Box 68760, ō been signed by the should be detached certificate has been page 2 or Attending Physicien: filled in by the funeral director, After death. Director: within 24 hours after To the Funerel Dire To the Hospitel completely

with the Maryland

filed within 72 hours after death

Baltimore, Maryland 21215-0036

?7 is marked other than "natural", or iteme 23e or 28e-f ehow treumatic event, the Medical Examinar must be notified at

al Hygiene.

Pages 1 and 2 should be fill treent of Health and Mental H tent: If Item 27 Is marked ot

other f

physician and

State Registrar

Back River Neck Road Baltimore Marylandzisz 31. Date fifed (Month, Day, Year) 32. Registrar's Signature 2006

201-109

**ORIGINAL** 

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Sabapalhi

Medical

29a. Certifier

(Check only

29b. Signature and title of certifier

		1 - For State of Maryland / De 23a per dr., G860 J	1.02.06dh eriilicate of Death	2. Date of Death	3. Time of Death
	dican dical	Daibala A. Webb	4b. City, Town, or Location of Death Millersville	Oct. 29, <sup>Day</sup> 20	7:50 A. M County of Death Anne Arundel
Funer Direct		5. Social Security Number 217-46-2705 6. Sex 1 M 2 F 61 Yrs. last birthda 2 F 61 Yrs.	y) If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth July 8, 194	9. Birthplace (State or Foreign Country) Maryland
ING Z1Z13-U035  be filed within 72 hours effer deeth with the Manyland tal Hyglene.  and other then "neture!", or teme 23e or 28e-f ehow  event, "the Musical Expire art must be confiled at	ector	10a. State 10b. County 10c. City, Town or	Location ownsville 10f. Zip Code	10g Citiz	10d. Inside City Limits 1 □ Yes 2√2 No en of What Country?
eth with	Funeral Director	1191 Mahogany Lane East	21032	Unit	ed States
OUS efter de rei', or item	by Fune	3 ₩ Widowed 4 Divorced Year or Dates:	<ol> <li>Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto</li> <li>□ Yes 2 No Specify:</li> </ol>		4. Race - American Indian, Black, White, etc.  Specify: White
DENTIMOYE, MATYIANG ZIZIS-0030 permit. Pages 1 and 2 should be filed within 72 hours efter deeth with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "neturel; or iteme 23e or 28e-f ehow eny injury or other traumatic event, the Madical Examinant or Institution of the contraction.	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  Com	cedent's Usual Occupation ve kind of work done during most of work . DO NOT use retired) mercial Underwrite:	ing	d of Business/Industry
Vicino (confidence) Mental Hygensteel other marked other matic event,	To Be C	17. Father's Name (First, Middle, Last)  Edward Sienkilewski	Mary M		
y Nicar and 2 sh salth and n 27 ie m		Joanna Syme/Power of Attorney 119	illing Address (Street and Number or Run 1 Mahogany Lane Eas		
SAITIMORE, Dermit. Pages 1 ar Department of Hea important: if item.		4 Donation 5 Other (Specify) Metro C		006 Ca	ation - City or Town, State
Depar impor	SUC.		Kirkiey⊴kütdick Fu 421 Crain Hwy. S.E		
Physicia /Medic		23a. Pant. Enter the disease, or complications that caused the death. Do not eshock, or heart failure. List only one cause on each line.			Approximate Interval Between Onset and Death
ificate be executed by g physicien and st the burial-transit	icai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last    Nephrolithiasis   Due to (or as a consequence of):			years
<b>≠</b> ⊃orai	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ⊠ No 9 □ Unknown  23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 4 □ Pregnant at time of death 9 □ Unknown	B⊟Ectopic pregnancy S⊟ Other ( <i>specity</i> )	23	ld. Date of delivery Month Day Year
equires that en signed b	<u>م</u>	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacco use	e contribute to the cause of death?
2 8 B	Completed			24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No	24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No
Physicien: rthis certificater, ral director,	To Be		0.0	n <i>(Check</i> on <i>ly one)</i> me 5 ☐ Residence 6	□Other (Specify)
*Attending Physicien: The sr death. ** Attending Physicien: The sr death. ** Attent this certificate his by the funeral director, page	Certification:	27. Manner of Death  1 Alatural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	of 28c. Injury at	28d. Describe how injury	
Ital or Attending effections of Director: led in by the	Certifi	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (Street and City or Town, State)	Number or Rural Route Number,
within 24 hours after or 75 the Funeral Disconnision of the completely filled in	Medicai	29a. Certifier (Check only one)  29a. Certifier (Check only one)  Certifying Physician: To the basis of examination and/or and manner stated.	ath occurred at the time, date and place, investigation, in my opinion, death occurr	and due to the cause(s) ared at the time, date and p	nd manner as stated. slace, and due to the cause(s)
within 2	Me.		29c. License number		signed (Month, Day, Year)
(2)		30. Name and address of person who completed cause of death (Item 23a) (Typ		100/0	7000
	State strar	31. Date filed (Month, Day, Year) 32. Registrar's Signature	TISK TO ICU, ISALI	imore he	V (1256

DHMH 17 Rev 1/2001

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ın Hwang			ate of	Maryland		artment of		d Mental	l Hygiei	ne	-	200	c 010
		1- For State Registrar			Cei	rtificate of	Death			Reg	No.	200	6 348
Physici		1. Decedent's Name (First, Midd	le,Last)							te of Death	21/	Year	3. Time of Death
ledical Exami	ner	Bun H. Whang							Oct	nth D tober 29,	2006	T Cal	1507 hrs
		4a Facility Name (if not institution		reet and number	)	4	o. City, Town, o		eath			inty of Deat	h
		Rt. 66, 1 mile north of	1-70				Smithburgh	1			Wasi	hington	
Funeral		5. Social Security Number	6. Sex	7. As	ge (In yrs. I	last birthday)	If Under 1 Yea			ate of Birth (	MM/DD/Y		rthplace (State or
Director		none	1 M	2[X]F	89	Yrs.	Months Day	s Hours	Min	2/23/19	016	Forei Co	ountry) Korea
	- 1	Usual Residence of Decedent					<u> </u>			2/23/15	710		
ám		10a. State 10b. County			10c. City,	, Town or Locatio	n						10d. Inside City Li
nd show		MD Washi	nato	n		Smithsbu	ıra						1 Yes 2 X
aryla 8a-f ator	ğ	10e. Street and Number			•		10f. Zip Code			10g	Citizen o	of What Cou	intry?
vith the Maryland s 23a or 28a-f show a e notified at once.	Director	22518 Jeffersor	יז [מ	a			21783			Α,		_	
with 18 23;		11. Marital Status		2. Was Deceden	t Ever in U	.S 13. Was	Decedent of Hi	spanic Origin?	(Specify Y		Korea 14. F		rican Indian, Black,
eath item	Funeral	1 Never Married 2 M	arried	Armed Forces			s, specify Cuba					White, etc.	
ierd ", or		3 X Widowed 4 Div	orced if	Yes 2  Yes, Give Year	X No	1 1	Yes 2X No	specify:			Spec	ofy As:	ian
urs al tural	ğ	15 Decedent's Education (Spe	cify only h	Dates. nighest grade co:	mpleted)	16a. Decedent			d of work do	ne 16		of Business	
2 ho	i e	Elementary/Secondary (0-12)		College (1-4 or		during ma	st of working life	DO NOT use	e retired)				
hhn 7	힐	6				Home	emaker				,	orm h	omo.
d wil	Completed	17. Father's Name (First, Middle.	, Last)			HOME	maxer	18.Mother's N	lame (First,	Middle, Mai		own ho	one_
21215-0036 uld be filed within 7 Mental Hygiene marked other than r event, the Medica	B B	Byung Chul Wha	ana					unobt	ainah	10.	Sona	,	
21; uld b Men mar	리	19a. Informant's Name/Relations		, Print )		19b Mailing	Address (Stre					Town, State	e. Zip Code)
MD d 2 shoulth and n 27 is aumatic		Gil Su Kim				1	Jeffers				-		
	1	20a. Method of Disposition	7.0	<del></del>		Place of Disposit	ion (Name of ce	metery,	Date				Town, State
orther		1 Burial 2 X Cremation		Removal from S	iaie	crematory or other	•						
altimore, mit Pages I an partment of Hee portant: If ite ury or other tr		4 Donation 5 Other St. 21. Signature of Funeral Service		-7	Nat	ional Cr	rematory	7 1	1/4/0	6	Fall	ls Chu	urch VA
Bal Permi Depai Impo		21. Signature of Funeral Service	Licensee	t.	/	-iry	me and Addres	s of Facility <b>en Funer</b>	al Hom	e @ MME	, Inc		
		23a. Part I. Enter the disease, or	T/	Nen	2	7250	Wichitar	n Flyl.	, alkr	dro, M	D 210	75	-
Physician /Medical		failure. Ist only one cause	on each	ine.	i ine deain	. Do not enter the	e muche of drymig	such as carn	inc or respir	al Ty arrest,	snoom, o	r neart	Approximate Inte Between Onset
Examiner		Immediate Cause (Final disease	_	Itiple Injuries									Death
<i></i>		or condition resulting in death)	Due	to (or as a cons	equence o	of):							
	ا ۾	Sequentially list conditions, if any, leading to immediate	b	to (or as a cons	equence o	\f\·							
	Ę	cause. Enter Underlying Cause	C.	10 (0) 40 4 00110	requerioe o	,,,,.							
/ = =	Examiner	(Disease or injury that initiated events resulting in death) Last		to (or as a cons	equence o	of):							1
executed an and al - transit	쁴		d										
a a e	dical	UNPENDED	A	MENDED									
Division of Vital Records, P.O. Box 68760, within 24 hours after death Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buri	Š	IF FEMALE:	1 7	23c. If yes, outco	me of preg	nancy					23d Dat	te of deliver	у
687 ertific ding p	Physician/Me	23b Was decedent pregnant in the past 12 months?	ne .	Live birth			death 3	Ectopic pre	egnancy		Mont	th	Day Year
ath ce	Sici	1 Yes 2 No 9 Uni		Pregnant a	t time of de	eath 5 Oth	er (Specify)						
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cords, P.O. Bian requires that the de has been signed by the should be detached for should be detached for the strong to the strong	by P	Part II. Other significant condit	ions co	ntributing to dea	th but not r	esulting in the un	derlying cause	given in Part I.	23				the cause of death?
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requestional	Completed								24	4a. Was an autopsy	24		utopsy findings availa
tal Reco cian: The law certificate has ector, page 2 si	티								—   <sub>.r</sub>	performe		death?	
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Division of Vital Records, tal or Attending Physician: The law requirers after death an Director: After this certificate has been siled in by the funeral director, page 2 should be	Be	examiner?	Hosp	ortal: 1 Inneti	ent 2	ER/Outpatient		Other N				0 [ ] 01	
of Vi ing Physi After this uneral dir	유	1 ✓ Yes 2 No 27. Manner of Death		28a. Date of Inj		28b. Time of Inj		ry at Work?	ursing Home	e o Res		6 V Othe	r Scene
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ivisior or Attend after death Director: in by the	äti		stigation										
in b	ij		ld not be			ome, farm, street	factory, office	ouilding, etc.		cation (Stre Town, State		umber or Ru	ural Route Number, (
Div Hospital of 24 hours al Funeral Ditel	Certification:	4 Homicide	rmined	(Specify) Ma	ajor Roa	d / Highway			Rt. 66	3, 1 mile i	north of	f I-70, Sr	nithburg, MD
e Ho 1 24 h e Fui etely		29a Certifier (Check only 1 Certifying P	hysician:	To the best of n	ny knowled	ge, death occurre	ed at the time, d	ate and place,	and due to	the cause(s	) and mar	nner as star	rted
To the Ho within 24 h To the Fur	Medical	one) 2 Medical Exa	miner:Or an	i the basis of exa d manner stated	imination a	and/or investigation	on, in my opinior	n, death occurr	red at the tir	ne, date and	d place, a	nd due to th	ne cause(s)
E > F o	ž	29b. Signature and title of certifie	er				29c. Licens	se number		25	9d Date s	signed (Mo	onth, Day, Year)
		Hanch 9 noll	NIL	MA			O.C.	M.E.		0	October	30, 200	6
		30 Name and dress of person	who com	pleted cause of	death (Itom	23a)							
10	ļ	Pamela E. Southall, N		ssistant Med	,	,	Penn Stree	t. Baltimore	e. MD 21	201			
,	tate	31 Date filed (Month, Day, Year)			ar's Signati		. 5.111 51166	-, Datamore	C, 141D 2 1	201			
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		1 - For State Registrar		State of M	aryland		artment of trificate of	Health and Death	Mental Hy	gienez (	06	34845
Physici	an	1. Decedent's Nam	e (First, Middle, L	ast)					2. Date of De	eath Day	Year	3. Time of Death
/Medic		ERNEST		K			WIESENFE		<b>OCTOBER</b>	30 2	2006	12:36 A M
Examin	er	, ,		ive street and number)			4b. City, Town,	or Location of Deat		4c. Coun	ty of Death	
- Francis		5. Social Security N	HOSPITAL		e (In vrs. la	ast birthday)	If Under 1 Year	BALTIMOF If Under 24 Hrs		rth	9 Birthi	N/A place (State or Foreign
Funeral Director		215-24-		1□M 2□F	82	Yrs.	Months Days		03/20/1	ay, Year)	Cou	ntry) MD
		Usual Residence of	Decedent						U3/ 20/ I	324	1	
the Maryland 28a-f show	tor	MD	BALT	MORE		, Town or Lo BALTIM					1	10d. Inside City Limits 1 ☐ Yes 2 X No
with the a or 28a	Director	10e. Street and Nu					10f. Zip Code			10g. Citizen of	What Cour	ntry?
death w		3613 AN	TON FARM	1S ROAD			21208			U.	S.A.	
er de	Funerai	11. Marital Status		12. Was Decedent Armed Forces?		S. 13. V	Vas Decedent of Yes, specify Cut	Hispanic Origin? (S ban, Mexican, Puerl	pecify Yes or No to Rican, etc.)		ace - Americ ack, White,	
ours after iral', or ite	þ	1 ☐ Never Marr	ied 2 Married 4 □ Divorced	1 ☐ Yes 2 ☐ If Yes, Give X Year or Dates:	No .		I□Yes 2XINo	Specify:		Spec	ity: WHI	TE
within 72 hours ene. then "natural", he Medical Exe	Completed	(Spec	15. Decedent's li city only highest g			(Give	lent's Usual Occu kind of work done OO NOT use retire	during most of wor	rking	16b. Kind of	Business/In	dustry
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lid be lental ked c	ToB	<b>JOSEPH</b>				KATZ		IRENE			ZAM	OISKI
s 1 and 2 should be filed if Health and Mental Hygi Itsm 27 is marked other other traumatic svent, II	-	19a. Informant's N	ame/Relationship	(Type, Print)		19b. Mailin	g Address (Stree	t and Number or Ru	ırai Route Numb	er, City or Town		
and 2 Baith a n 27 is		JOSEPH WI	ESENFELD	/ HUSBAND		3613 /	ANTON FA	RMS ROAD	- BALTI	MORE, M	D 212	08
of He of He if its or oth		20a. Method of Dis		Removal from State	ce	metery, cren	sition (Name of natory or other pla		Date	20c. Location		
Pages ment of ant: if it ury or o			5 Other (Spec		BALT	IMORE	HEBREW (	CONG. 11/	01/2006	BALTI	MORE,	MD
permit. Pages Depertment of Important: if it any injury or one		21. Signature of Fu	ineral Service Lice	ensee	_		. Name and Addr	2	OL LEVI			
20 5 4 Q		220 Part Salar	20/	Ohon-				STERSTOWN			ILLE,	
Physician		shock, or hea Immediate Cause disease or condition	rt failure. List onf (Final	nplications that caused y one cause on each li	ne.				correspiratory a	rrest,		Approximate Interval Between Onset and Death
/Medical Examiner		resulting in death)	-	Due to (a) as	a consequ	ence of):						
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ite be iysicie ne bur	ical		•	d								
artifica ing ph a as th	Med	IF FEMALE:										
To the Hospital or Attending Physician: The law requires that the death certificate b within 24 hours efter death.  To the Funeral Director: After this certificate has been signed by the attending physic completely filled in by the funeral director, page 2 should be detached for use as the b	by Physician/Med	23b. Was deceden in the past 12 1 Yes 2 5 9 Unknown	months?	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal	death 3 🗆	Ectopic pregnand Other (specify)	ey .			ate of delive lonth	ery Day Year
w requires that the deben signed by the should be detached	y Ph	Part II. Other signif	icant conditions	contributing to death b	ut not resul	lting in the ur	iderlying cause gi	ven in Part I.	23e. Did t	obacco use cor	ntribute to th	ne cause of death?
quire on sig uld bu	ed b	in	rythme	~					10	Yes 2 No	3 🗌 Prob	pably 4 Unknown
aw re	ompieted								24a. Was		. Were auto	psy findings available
sician: The law certificate has t irector, page 2 s	E O								autor perfo	ormed?	death?	mpletion of cause of 2□ No
ctor,	Bec	25. Was case refer examiner?	red to medical					26. Place of Dea				
hysic this c	ဥ	1 ☐ Yes 2 🖸		Hospital: 1 ☐ Inpatie		R/Outpatient	3 DOA		ome 5 Resi	dence 6 □Ot	her (Specif	<b>y</b> )
After Lunera	on:	27. Manner of Deat 1 (Enatural	5 Pending	28a. Date of Inju (Month, Da	ry y Year)	28b. Time of Injury	28c. Inju Wo		28d. Describe	how injury occu	rred	
death death stor: / the	cat	2 ☐ Accident 3 ☐ Suicide	investigate 6 Could not	De Disea of Inc	unc - At hor	no form elec	M 1	]Yes 2□No	29f Location /	Stmot and Num	bos os Ours	Il Route Number.
i or A efter Dirsc	ertification:	4 Homicide	determine	building, et	c. (Specify)	)	et, ractory, onice		City or To		Der or Hura	ii Houte Number,
To the Hospital or Attending Physician: within 24 hours effer death. To the Funeral Director: Affer this certific completely filled in by the funeral director,	dical C	29a. Certifier (Check only one)	1 Certifying P	hysician: To the best miner: On the basis of and manner sta	examinati	vledge, death on and/or inv	occurred at the trestigation, in my	ime, date and place opinion, death occu	, and due to the rred at the time,	cause(s) and m	nanner as st	lated. o the cause(s)
omple	Med	29b. Signature and	title of certifier	and mainter 50			29c. Licen:	se number		29d. Date sign	ed (Month,	Day, Year)
7		<b>)</b> /	XX.	Mo			61	9914		10/20	106	
5		30. Name and addr	ess of person who		eath (Item	23a) (Type, i					-	
)		InnT	FINEM	0 1671	) F	Me k	d Lue	the alle	md	21082		
Sta Registr	te ar	31. Date filed (Mon	NOV 0 2	2006 32. Redistri	ar's Signati	ure .	and .	nter ville				
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 34846 Certificate of Death Reg. No. 2. Date of Death 1 Decedent's Name (First Middle Last) 3 Time of Death Year **Physician** :44AM Charlotte Bovers OCTOBER 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hagerstown Washington Western Maryland Hospital Center If Under 1 Year | If Under 24 Hrs. 8. Date of 8irth (Month, Day, Year)
July 25,1923 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 ☐ M 2 🛱 F July 217-16-2586 Director 83 Maryland Usual Residence of Decedent with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits ir than "natural", or items 23s or 28e-f ehow the Mudical Examinational be notified at 1 Yes 2 □ No Director MD Washington Hagerstown 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 1500 Pennsylvania Ave. 21742 U.S.A. by Funerai filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 8lack, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Tes 2 No Specify: White 3 ♥ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of 8usiness/Industry th and Mental Hygiene.
7 ie marked other than 'traumatic event, the Ma Elementary/Secondary (0-12) College (1-4or 5+) Manager Communications 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Samuel H. Conrad Mary Esther Sinn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit Pages 1 and 2:
Department of Health ar
Important: If Item 27 ie
any injury or other trau Krista L. Strock/Daughter 16 Marten Trail, Fairfield, PA 17320 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1X Burial 2 □ Cremation 3 □ Removal from State Rest Haven Cemetery 4 □ Donation 5 □ Other (Specify) 10/30/2006 Hagerstown, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rest Haven Funeral Chapel S.Mark 1601 Pennsylvania Ave., Hagerstown, MD 21742 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval 8etween Onset and Death Immediate Cause (Final disease or condition resulting in death) AMYOTROPHIC LATERAL SCLEROSIS **Physician** /Medical Due to (or as a consequence of): Examiner 15 HOTHIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of burial-tran Due to (or as a consequence of): Physician/Medical for use as the IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐No Year Month Day 4 Pregnant at time of death 5 Other (specify) detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ pe CHRONIC OBSTRUCTIVE PULMONARY 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate has page 2 1 Yes 2 No Be ( director, 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DQA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No this funeral 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 Hospitel or Attending Injury 1. Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after death To the Funeral Director; 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 1/2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical completely (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD D0062895 26, 2006 CUTOBER 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) 1500 Pennsylvania Avenue Hagerstown, MD 21742 2. Registrar's Signature 31. Date filed (Month, Day, Year) Gorden State

Registrar

NOV 0 2 2006

State of Maryland / Department of Health and Mental Hygiens For State Registrar Certificate of Death Reg. No. edent's Name (First, Middle, Lost) Time of Death 2. Date of Death **Physician** ALLINGER Month /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Annapolis

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year)

Aug. 11, 1922 Anne Arundel Medical Center Anne Arundel 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ■ M 2 NF Director 577-24-5140 84 Yrs Maryland Usual Residence of Decedent with the Maryland 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits rthan "natural", or itama 23a or 28e-f show the Medical Examinar must be notified at Anne Arundel Severna Park Director 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 715 Benfield Blvd. 21146 USA Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status l □ Yes 212 No f Yes, Give Year or Dates: 1 Never Married 2 Married nd 21215-0036 Specify: White 1 ☐ Yes 2 ☒ No þ 3 ₩ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. ent: if Item 27 is marked other then " Elementary/Secondary (0-12) College (1-4or 5+) Library Technician Prince Georges County or other traumatic svent, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Edward Duncan Margaret Miller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar important; if item 27 is any injury or other trau Duncan S. Clements/Nephew 503 Likeston Court Severna Park, MD 21146 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition October 17 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Cedar Hill Cemetery 4 ☐ Donation \_5 ☐ Other (Specify) 2006 Suitland, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Barranco & Sons, P.A.
495 Gov. Ritchie Hwy. Severna Park Funeral Home Severna Park, MD 21146 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death lomediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine attending physicien and for use as the burial-transit Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant Division of Vital Records, P.O. Bd 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown signed by the atte Month Day Year 4☐Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 4 Unknown 1 Yes 2 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy 2 (A) 1 ☐ Yes : After this certification and funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 1 Yes 2 No 1 Depatient 2 ER/Outpatient 3□ DOA 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending investigation Injury death. 1 ☐ Yes 2 ☐ No after death the 3 🗌 Suicide 6 Could not be determined within 24 hours after de To the Funeral Direct completely filled in by ti 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 10 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a Certifier 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) no completed cause of death (Item 23a) (Type-Print) THUN 31. Date filed (Month 32 Registrar's Signature State 8 2006 Registrar

			1 - For State Registrar	State o	f Marylar			nt of H te of L		Mental Hy	gienę Reg. No.	11116	34848
	Physici /Medio	al	Decedent's Name (First, Middle, La Cecilia Eve     A. Facility Name (If not institution, giv	lyn 1	Brauns	tein	45 6:5	. Taura	Location of Dea	2. Date of De Month	r 15	, 2006	
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ů.	Funeral		5. Social Security Number 6. S 211-09-3622	ex □M 2 <del>Q</del> F	7. Age (In yrs. 90	last birthday) Yrs.	If Und Months	er 1 Year Days	If Under 24 Hrs Hours Min	(Month. D.	rth av, Year)	9. Bit	rthplace (State or Foreign ountry)
3.7	Director		Usual Residence of Decedent	Λ					A	ugust	0,19	10	PA
	fanylar show	ō	10a. State 10b. County	1	10c. Ci	ty, Town or Lo							10d. Inside City Limits 1 Yes 2 No
	r 28e-i	Director	MD Cha	rles		N.	anje	moy ip Code			10g. Citi	zen of What C	ountry?
	23a o	rai D	10535 Ox Cart	Lane				2	20662			US	A
36	d within 72 hours after death with the Maryland Jone. Ir than "natural", or Items 23s or 28e-f show Ira Macical Examinat must be ricilled at	by Funeral	11. Marital Status  1 Never Married 2 Marned  Widowed 4 Divorced	12. Was Dec Armed Fo 1 Tes If Yes, Gi Year or D	ve			edent of Hi ecify Cuba 2XNo	spanic Origin? ( n, Mexican, Puel Specity:	Specify Yes or Norto Rican, etc.)	0-	14. Race - Am Black, Whi Specify:	
2-0	72 hou natura	eted	15. Decedent's Ed (Specify only highest gra			16a. Dece	dent's Us	ual Occupa	ation during most of wo	orkina	16b. Ki	nd of Business	s/Industry
121	within ene. then "	Completed	Elementary/Secondary (0-12)	College (	1-4or 5+)	life.	DO NOT	use retired	)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		u	ome
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Maryland 21215-0036	Menta Menta arked artic ev	To B	Joseph Arlet						Eva	Otcko			
Mar	12 sho h and 7 is ma trauma		19a. Informant's Name/Relationship (							lural Route Numb	-		
re,	Health tem 27 other tr		David Braunste  20a. Method of Disposition		20b. I	Place of Dispo	osition (N	ame of		,Nanje		MD 20 cation - City of	
E C	Pages nent of int: If it iry or o	٠,	1 ☐ Burial 2 ☐ remation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif	Removal from	Bri		$1\mathrm{d}$ – E	cho1	s 10/1	8/06	Char	lotte	Hall,MD
Baltimore,	permit. Pages Department of Important: If I any injury or once.		21. Signature of Funeral Service Licer	Ehu	M009	45	AREF	ART ST.	ECHOLS MARY'A	FUNER VE. LA	AL H PLA	OME,P	.A. 20646
Г			23a. Part1. Enter the disease, or comshock, or heart failure. List only	plications that one cause on e	caused the dea each line.	th. Do not en	ter the mo					·	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a	Card	iomyo	path	У			·		
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2.7	sit ad	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	(or as a consec	quence of).					-		
	cate be executed obly sician and the burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to	(or as a consec	quence of):	-						
8760,	te be e ysiciar le buri			d									
9	entifica ing ph e as th	Medi	IF FEMALE:	- 14 10									
.O. Box	that the death certificate be executed sed by the attending physician and detached for use as the burial-transit	Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 X No 9 ☐ Unknown	1☐Live t	tcome of pregn birth 2 □ Feta nant at time of d own	aldeath 3	Ectopic Other (	pregnancy specify)			2	23d. Date of de Month	blivery Day Year
rds, P	lew requires that the as been signed by th 2 should be detache	þ	Part II. Other significant conditions of	ontributing to d	eath but not res	sulting in the u	inderlying	cause give	en in Part I.				o the cause of death?
Vital Records,	The le ate has page 2	Completed								24a. Was auto perfi 1 Yes		24b. Were a prior to death?	utopsy findings available completion of cause of
Vita	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medicat examiner?	Hospital:				Oth		eath (Check only	$-\mathbf{A}$		
of	Phys rthis ral dii	To To	1 Yes 2 No 27. Manner of Death	28a. Date	of Injury	28b. Time o		28c. Injury Work	4 🗀 Nulsing	Home 5 Res			ecify)
ion	fe A P din	atior	¥ Natural 5 ☐ Pending 2 ☐ Accident investigation		th, Day Year)	Injury	м		(? Yes 2 □ No				
Division	or Attendation Direction by	Certification:	3 Suicide 6 Could not b	280. Place	of Injury - At h ing, etc. (Speci	iome, farm, sti	reet, facto	ry, office			(Street and		lural Route Number,
	Hospitel 24 hours a Funeral letely filled	edicai	29a. Certifier Certifying Ph (Check only one)	niner: Øn the b	best of my knows asis of examination of examinations of examinations.	owledge, deat ation and/or in	h occurre vestigatio	dat the tim n, in my op	e, date and place pinion, death occ	e, and due to the surred at the time,	cause(s) date and	and manner a place, and du	s stated. e to the cause(s)
	To the I within 2. To the I complet	Med	29b. Signature and tife of certifier	and man	nor stated.		2	9c. License	number		29d. Dat	e signed (Mon	th, Day, Year)
			150	1	Com		-	000	3342	6		10/18	3/06
M	P 12		30. Name and address of person who Larry Jenkins				_		La Pl	ata,MD	206	46	
	Sta Registi		31. Date filed (Month, Day, Year)  OCT 1 9	2006 32. F	gistrar's Sign	ature A	book						

State

Registrar

Bruce G.

31. Date filed (Month, Day, Year)

100 50%.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2006

3 0

MPH

32. Registrar's Signature

			1. State of Maryland / Department of Health and Maryland / Department of Health / Department of Health / Department of Health / Department	Mental Hy	giene2 () ( Reg. No.	16 34850
			Decedent's Name (First, Middle, Last)	2. Date of Dea	ath	3. Time of Death
	Physici /Medic		Allen Leroy Bowman	Month	25 O	6ar 0035 M
	Examin		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death  Complexion  4b. City, Town, or Location of Death  Complexion	D	4c. County of Alle	Death Gany
	Funeral Director		5. Social Security Number 6. Sex 1 N M 2 F 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birt (Month, Da 5/2/19	h g	Birthplace (State or Foreign Country)  laryland
	Du *		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	Aaryii Sho	5	MD Garrett Oakland			1 ☐ Yes 2 🕅 No
	158 128a-	rect	10e. Street and Number 10f. Zip Code		10g. Citizen of Wh	at Country?
	death with the Maryland ms 23a or 28a-f show must be notified at	a D	240 Sanders Lane 21550			USA
	or Items	Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Sp. 14. Was Decedent of Hispanic Origin?)	pecify Yes or No		American Indian, White, etc.
0	or ite	by Fu	1 □ Never Married 2 ሺ Married 1 □ Yes 2 ሺ No If Yes, Give 1 🛣 Yes 2 □ No Specify:	o i nouri, otc.)	Specify:	
5	72 hours naturel', dical Exa		3 Widowed 4 Divorced Year or Dates:  15. Decedent's Education   16a. Decedent's Usual Occupation			White
<u>.</u>	n na	Completed	(Specify only highest grade completed) (Give kind of work done during most of work	king	16b. Kind of Busin	18SS/Industry
7	filed within Hygiene. Ither then Int, the Me	E	Elementary/Secondary (0-12) College (1-4or 5+)  8th  Laborer		Const	ruction
and	be filed ntat Hygi od otther event,	Bec	17. Father's Name (First, Middle, Last)  18. Mother's Name	ne (First, Middle,	Maiden Surname)	
<u>X</u>	should to	၉	Woodrow Bowman Alice		Кт	nox
Mar	C1 (a = 0		19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rui			ate, Zip Code)
<b>a</b>	s 1 and if Heelth Item 27 other tr		Linda Bowman/ wife 240 Sanders Lane, Oak 20a. Method of Disposition 20b. Place of Disposition (Name of	Date Date	D 21550 20c. Location - Ci	tv or Town State
	Pages nent of i int: If It iny or o		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place)	28/06	Oakland.	
baltimo	그윤원충	1			Funeral H	
Ď	Depermine Depermine Properties of Properties	. 4	32 S. Second St.,			
	Physician		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line.	or respiratory ar	rest,	Approximate Interval Between Onset and Death
	/Medical		disease or condition resulting in death)  Due to (or as a consequence of):	9	KLVKI	< > 2 months
	Examiner	_	Sequentially list conditions, b. Resection of Rt lung	In	Canc	e
Т	nsit	ılner	if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of):	Cara	0	
	xecut and al-trar	Examin	that initiated events resulting in death) Last  Due to (or as a consequence of):	XX VC	7	717ean
0/0	icate be executed physicien and s the burlal-transit	dical	a Atrial Epsillation	with	Pask o	06
Ä	rtificat ng phy as th	00				
ŏ	death certif e attending od for use as	Physiclan/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy  1  Live birth 2 Fetal death 3 Ectopic pregnancy		23d. Date of	
	ne dee the at hed fo	/sicl	1 Yes 2 No 4 Pregnant at time of death 5 Other (specify) 9 Unknown		Month	Day Year
	irres that the death certifications signed by the attending does not use as	Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did to	bacco use contribu	ute to the cause of death?
cords,	law requires thet the as been signed by th 2 should be detache	d by				□ Probably 4 □Unknown
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Ĕ	The It	E		autop perfor	sy prio med? dea	or to completion of cause of th? Yes 2□ No
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5	hysic this co	၉	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Cther: 4 ☐ Nursing Ho	ome 5 Resid	lence 6 Other	(Specify)
SION	After funer	ion:	27. Manner of Death  1 ☑ Natural 5 □ Pending (Month, Day Year)  2 ☐ Accident investigation (Month, Day Year)  2 ☐ Accident investigation (Month, Day Year)	28d. Describe h	low injury occurred	
2	death death ctor; y the	Certification:	3 Suicide 6 Could not be	28f Location (S	Street and Number	or Rural Route Number.
5	el or v s efter il Dira	Sert	4 ☐ Homicide building, etc. (Specify)	City or Tow		77 Florid Florid Florid Florid
	To the Hospitel or Attending Physicien: The law within 24 hours eiter death. To the Funarel Director: Atten this certificate has completely filled in by the funeral director, page 2.	edlcal (	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occur and manner stated.	and due to the orred at the time, or	cause(s) and mannedate and place, and	er as stated. I due to the cause(s)
	To th To th Compl	Me	29b. Signature and title of certifier 29c. License number		29d. Date signed (/	Month, Day, Year)
			John Mellanns M-D- 17526	6	ctober	524-500E
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print)			
			DR. JOHN MEHANNA 921 SETON DRIVE, CI 31. Date filed (Month, Day, Year) 32. Registrar's Signature	umber	land, ir	10 21502
	Sta Registr	_	OC 2 7 2006 32. Hegistrar's Signature			

			1 - For State Registrar	State of Marylan			nt of H		nd Me		giene	11116	34851	
			Decedent's Name (First, Middle, Last)							2. Date of Dea	ıth		3. Time of Death	
	Physici		Ronald Wayne Be	ckman						Month 09/28	Day 3/20		11:55 p <sup>M</sup>	
	/Medio	-	4a. Facility Name (If not institution, give s			4b. Cit	, Town, or	Location of	Death			County of Dea		
			Garrett County	Memorial Hosp	ital		0ak	land				Garı	rett	
F	uneral		Social Security Number     6. Sex	3.1.2	last birthday)	If Und	er 1 Year Days	If Under 2 Hours	Min.	8. Date of Birth (Month, Day	Year)	9. Bi	rthplace (State or Foreign	
	irector		217-42-0414	<sup>1M 2□ F</sup> 64	Yrs.	WIOTIGH	Days	riodis	IVIIII.	12/04/	194		MD	
pu	2		Usual Residence of Decedent  10a. State 10b. County	10c Cit	y, Town or Lo	cation		-					10d. Inside City Limits	
laryla	whow	5											1 ☐ Yes 2 X No	
Pe N	28s-f	Director	MD Garrett  10e. Street and Number	0	akland		- O-d-			-	10- 04			
with	10.4	늅	1528 Sunnyside R	ond		101. 2	ip Code	1550			rog. Citi.	zen of What C	ountry?	
be filed within 72 hours after deeth with the Maryland tal Hyolene.	od other than "natural", or liams 23a or 28a-f ahov avant, ita Mudical Examinar must ba nolifiad at	Funeral		12. Was Decedent Ever in U	S 12 1	Was Doo		1550	in? (Snov	ifu Vac or No		USA 14. Race - Am	encan Indian	
ter d	Trans	Š	1 ☐ Never Married 2 ☑ Married	Armed Forces? 1 ☐ Yes 2 💢 No	.3.	If Yes, sp	ecify Cuba	n, Mexican,	Puerto R	cify Yes or No- lican, etc.)		Black, Wh		
urs al	, o	þ	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 🗌 Yes	2 <b>X</b> No	Specify:				Specify:	White	
2 ho	cal	Completed	15. Decedent's Edu		16a. Dece	dent's Us	ual Occupa	ition			16b. Kii	nd of Business	s/Industry	
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2 € ₹	vent	Be	17. Father's Name (First, Middle, Last)					18. Mother	's Name	(First, Middle,	Maiden	Sumame)		
uld b	it c	2	Joseph Eugene Be	ckman				F.	loss:	i Mae S	weit	tzer		
2 should	la marked other than aumatic avant, its Mi		19a. Informant's Name/Relationship (Ty	pe, Print)	19b. Mailir	ng Addre	ss (Street a	ind Number	r or Rural	Route Numbe	r, City o	r Town, State,	Zip Code)	
end	n 27 ar tr		Elaine Beckman/W	ife	152	8 Su	nnysi	de Ro	ad,	0akland	, MI	2155	50	
S T	r oth		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ R	1 .	Place of Dispo cemetery, crei	sition (Nation)	ame of other place	9)	Da	ate	20c. Lo	cation - City o	r Town, State	
Pages ment of	ury o		4 □Donation 5 □Other (Specify)		rrett	Co. 1	Mem.	Gdns I	10/5/	/2006	0ak	cland,	MD	
rmlt.	Important: If Itam 27 Ia marke any Injury or other traumatic: once.		21. Signature of Funeral Service Licens	*0 - 0	22	2. Name a	and Addres	s of Facility	St	ewart F	'une 1	ral Hom	ne	
3 88	E = 8		Didy	War V		32	South	Secon		reet,				
/M Exa	sician end the burial-transit	i Examiner												
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for the Hospital or Atlanding Physician: The law requires that the death certificate be executed within 24 hours after death	igned by the ettending p be detached for use as f	Physician/Med	IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of d 9 □ Unknown	I death 3	Ectopic Other (s	pregnancy specify)				2	23d. Date of de Month	elivery Day Year	
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die S	n sig	å p	Pulmonary Embolis	m, Anticoagul	ation	Ther	apy,			1 □ Y	es 2[	□No 3 <u>K</u> ]F	Probably 4 Unknown	
9 €	s has been sig ge 2 should b	Completed	History of Smoki	ng						24a. Was a	an	24b. Were a	utopsy findings available	
l ed	age 2	Ë								autop: perfor	med?	prior to death?	completion of cause of	
ċ	or, p	Ü	25. Was case referred to medical			-		26 Place	of Death	1 ☐ Yes (Check only or	2∏ No	1 L Ye	s 2□No	
ysick	s cer direct	0	examiner? 1 ☐ Yes 2 ☑ No	lospital:	ER/Outpatier	nt 3 🗆 🖸	Othe Othe	AP-		e 5 Resid		Other (So	acifu)	
£ .	er thi	F :	27. Manner of Death	28a. Date of Injury	28b. Time o		28c. Injury Work			8d. Describe h			scriy)	
g de	e fun	atio	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury	М		res 2□N	lo					
al or Atta	ministers to consider the formal director, page completely filled in by the funeral director, page	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Specif	ome, farm, str	reet, facto	ry, office		21	8f. Location (S City or Town			lural Route Number,	
ha Hospit	ha Funara pletely fills	Medical (	29a. Certifier 1  Certifying Physics (Check only one) 2  Medical Examin	sician: To the best of my knoner: On the basis of examina and manner stated.	owledge, deat ation and/or in	h occurre vestigatio	d at the tim	e, date and pinion, death	place, ar h occurre	nd due to the c d at the time, d	ause(s) late and	and manner a place, and du	s stated. e to the cause(s)	
To the	Tot	Σ	29b. Signature and title of certifier	~~		2	9c. License	number		2	9d. Date	e signed (Mon	th, Day, Year)	
		1	I foul to				MD 6	3335			10	/03/20	06	
			30. Name and address of person who co	mpleted cause of death (Item	n 23a) (Type,	Print)								
			Andrew M. Foy, M			glon,	, WV	26716	6					
	Sta Registi		31. Date filed (Month, Day, Year)	32. Registrar's Signa	ature	0								

ORIGINAL

State of Maryland / Department of Health and Mental Hygien 2 U U 6

25, 2006

22. Name and Address of Facility
Mattingley Carliner Funeral Home, P. A.
P.O. Box 270, Leonardtown, Maryland 20050

Certificate of Death

Examiner 26010 Prospect Hill Road 5. Social Security Number **Funeral** 1**X** M 2□ F 217-44-7562 Director 61 Usual Residence of Decedent 10a, State 10b. County item 27 is marked other then "natural", or items 23a or 28a-f show other treumatic event, the Medical Examinar must be notified at Directo Maryland St. Mary's 10e. Street and Number 26010 Prospect Hill Road Funeral permit. Pages 1 and 2 should be filed within 72 hours after of Department of Heelth and Mental Hygiene Important: if frem 27 is marked other then "natural", or Iten only injury or other treumatic event, the Medical Exeminations. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 þ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 17. Father's Name (First, Middle, Last) Be Edward Louis Buckler 19a. Informant's Name/Relationship (Type, Print) Loretta Faye Buckler / Wife 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □Donation 5 □ Other (Specify) Charles Memorial Gardens 23a. Part Immediate disease or Physician /Medical resulting in

1. Decedent's Name (First, Middle, Last) 2. Date of Death 5.50 Death October 20, 2006 Lawrence Edward Buckler Ам 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death St. Mary's Mechanicsville If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, June 11. Maryland 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2X No Mechanicsville 10g. Citizen of What Country? USA 20659 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 📉 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2 X No Specify: White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Route Salesman Bread Company 18. Mother's Name (First, Middle, Maiden Sumame) Lenora Cecelia Buckler 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 26010 Prospect Hill Road, Mechanicsville, Maryland 20659 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State October

Examiner

Physician

/Medical

al-transit physicien at the burial-t as esn

Box 68760

P.O.

Division of Vital Records,

ed by the attending detached for use as certificate has After this el or Attending P s after death. Il Director: After t d in by the funera To the Hospitel o within 24 hours at To the Funerel D

, or heart failure. List	only the cause on each line.	itory arrest,
Cause (Final condition death)	Due to (or as a consequence of):	R
ly list conditions, ing to immediate ter Underlying	b	
ease or injury d events death) Last	c	
E:	d.	
incodest proposet	23c. If yes, outcome of pregnancy	234

Sequential if any, lead cause. En Cause (Dis that initiate Examiner resulting in Physician/Medicai IF FEMALE 23b. Was d Date of delivery 1 I ive birth 2 Fetat death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 1 Yes 2 No Be ( 25. Was case referred to medicat 26. Place of Death (Check only one) Hospital: 1 Inpatient examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient Certification: To 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending Injury 1 Tyes 2 □No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a. Certifier 🧷 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature 29c. License number

nd the of certifier

D41728

29d. Date signed (Month, Day, Year) October 20, 2006

Leonardtown, Maryland

Approximate Interval Between Onset and Death

month

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Patrick Cross, M.D. P.O. Box 527, Leonardtown, Maryland 20650

31. Date filed (Month, Day, Year) State

OCT 2 3 2006



DHMH 17 Rev 1/2001

Registrar

		Registrar	inel .		- 061	rtificate	O UI L	Jean		2. Date of Dea	eg. Nor-	106	3. Time of	Death Death
Physici	1,001	Decedent's Name (First, Middle, La  Tolan Do	vid Beavan							Month October		2006	8:00	Λ M
/Medi	al	4a. Facility Name (If not institution, given				4b. City.	Town, or	Location of		occobe		nty of Death	<u> </u>	Л
Examir	er	24939 Beavan Co					aptio					t. Ma:		
Funeral Director		5. Social Security Number 6.		(In yrs. 1 54	ast birthday) Yrs.	If Under Months		If Under: Hours	24 Hrs.	8. Date of Birth (Month, Day November	13,195	9. Birth	nplace (State o untry) y land	r Foreign
and w		Usual Residence of Decedent  10a. State 10b. County		10c. City	, Town or Lo	cation							10d. fnside Ci	ty Limits
Maryl	tor	Maryland St. Mary	's	Ch	aptico	)							1 🗀 Yes	2 💢 No
or 28e	Director	10e. Street and Number				10f. Zip				1	10g. Citizen		untry?	
23a	rai	24939 Beavan Co	1	Superior III	C 10		0621	lianania Osu	-in2 /Cna	at. Vac or No	US		ncan Indian,	
ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "naturel", or items 23a or 28e-f ehow or other treumetic event, the Madical Exprinse must be notified at	Completed by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent If Armed Forces?  1  Yes 2 No If Yes, Give Year or Dates:			Was Deced If Yes, spec			gin? (Spec i, Puerto R	cify Yes or No- lican, etc.)		Black, White		
d 2 should be filed within 72 hours aft the and Mental Hygiene. 27 is marked other then "naturel", or treumatic event, the Modical Exptra	eted	15. Decedent's E (Specify only highest gi	ducation ade completed)		16a. Dece	dent's Usua kind of wo	al Occup	ation during mos	t of workin	ıg	16b. Kind o	f Business/	Industry	
	mpi	Elementary/Secondary (0-12)	Colfege (1-4or 5	+)		bo not us Lor Te					HV	AC.		
Hygie Hygie other i	ပိ	17. Father's Name (First, Middle, Las	t)		Selli	.01 10	SCIIII.		er's Name	(First, Middle,				
ild be fental rked c	To Be	James Benjam	in Beavan					Agn	es Ma	rie Hay	yden			
parmit. Pages 1 and 2 should be filed within Depertment of Health and Mental Hygiene. Important: If item 27 is marked other then ery injury or other freumatic event, Ina Magnes.		19a. Informant's Name/Relationship				•				Route Numbe			Zip Code)	
fealth m 27 her tr		Margaret Charlotte E	eavan / Wife	20h P	24939			rt, Cha		, Marylar			Town, State	
oermit. Pages t a Depertment of Hea mportant: if item any injury or othe		20a. Method of Disposition  1 XBurial 2 Cremation 3		Que	en of Pa	matory or o	other place	ce)	Octob					
nit. Parientmen ortant: injury		4 □ Donation 5 □ Other (Special Signature of Funeral Service Lice		7	emetery	2. Name ag	g Addre	ss of Facilit	27, 20		Helen,		TIKT	
Depermine Depermine Impo		Michael Hever	Hardiner	1	$- \mid_{\mathbf{P}}^{\mathbf{M}}$	o. Bo	Ley-G x 270	ardine , Leona	r Fune ardtow	ral Home n, Maryla	and 206	50		
Physician /Medical Examiner partial-Itausit	icai Examiner	23a. Part1. Enter the disease, or coshock, or heart failure. List online mediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		a consequence	uence of):			iti te					Interval Bet Onset and	Death
The law requires that the death certificate be evalue has been signed by the attending physician page 2 should be detached for use as the burial	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Feta	I death 3	⊒Ectopic p ⊒ Other (s <sub>f</sub>		у			23d.	Date of del Month	,	Year
signed by	b	Part If. Other significant conditions	contributing to death b	ut not res	ulting in the u	underlying	cause giv	ven in Part I			obacco use o		the cause of cobably 4	
l or Attending Physician: The law requires to alrecteath.  Director: Atter this certificate has been signed in by the funeral director, page 2 should be a	Completed									24a. Was autop perfor	rmed?	prior to death?	utopsy findings completion of c	available ause of
ician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:				. 0#	100		(Check only o				
Attending Physician: r death. ector: Atter this certification the funeral director;	ion: To	1 Yes 2 No  27. Manner of Death 1. Natural 5 Pending 2 Accident Investigat	Hospital: 1 Inpatie 28a. Date of Inju (Month, Da		28b. Time of Injury		28c. fnjui Wo		2	ne 5 Aesid 28d. Describe h			cify)	
or Attendi	Medical Certification:	2 Accident investigat 3 Suicide 6 Could not 4 Homicide determine	be ago Place of Inc	ury - At h	ome, farm, s fy)					28f. Location (S City or Tow		umber or Ru	ural Route Nun	nber.
To the Hospital within 24 hours a To the Funeral C completely filled	edicai C		Physician: To the best aminer: On the basis o and manner st	f examina										s)
To the To the complete	×	29b. Signature and title of certifier						se number			- (	-	h, Day, Year)	
		1614					0 50	1686			101	23/06		
		30. Name and address of person who GURDEEP . 5. CHY		death (fter			SPITE	. 1	00 R	ox 625	Lean	and town	n MOTA	650

DHMH 17 Rev 1/2001

			For State Ragistrar	State of I	Marylan				lealth a Death		lental Hyg	iene ()	06	34854	
****	Physici		Decedent's Name (First, Middle, Last     Jack	o BIE	BER						2. Date of Deat Month Oct . 1	7, Day 200	6 <sup>Year</sup>	3. Time of Death 6:08 A. M	
	/Medic		4a. Facility Name (If not institution, give Hebrew Home of G			ton		, Town, or	r Location o	of Death		4c. County	of Death		
	Funeral		5. Social Security Number 6. S		Age (In yrs.	last birthday)		er 1 Year	If Under Hours	Min	8. Date of Birth (Month, Day,	1	9. Birth	nery place (State or Foreign York	
サス	Director		Usual Residence of Decedent	**** 231	88	Yrs.					Sept. 3,	T918	MEM	1012	
Maryian	fedat	tor	MD 10a. State 10b. County Montgomer	у	10c. Cit	y, Town or Lo Ckvill	e e						10d. Inside City Limits 1 X Yes 2 ☐ No		
with the	a or 28a be not	Direc	10e. Street and Number 1801 East Jefferso	on St. #1	20		10f. Z	ip Code	20852	 2	1	0g. Citizen of		intry?	
:1215-0036 within 72 hours after death with the Maryland	f Health and Mental Hygiene. Item 27 Is marked other than "natural", or Iteme 23s or 28s-f ehow other traumatic event, I'm Medical Examiner must be notified at	by Funeral Director	11. Maritat Status 1 □ Never Married 2 各Married	12. Was Decede Armed Force 1 XYes 2	ent Ever in U.		If Yes, sp	ecify Cuba	in, Mexicar	igin? (Spe n, Puerto	ecify Yes or No- Rican, etc.)	14. Rad Bla	ce - Amer ck, White		
<b>215-0036</b> thin 72 hours at	tural',	ed by	3 ☐ Widowed 4 ☐ Divorced	ff Yes, Give Year or Date	s: WWII	16a. Dece		2 No	Specify:			Specif 16b. Kind of B		ite	
<b>21215</b> od within 72	jiene. r than "na Lha Madic	Completed	(Specify only highest gra		or 5+)	(Give	kind of v	rork done i use retired	durina mos	t of worki	ing		othin		
Maryland 2	Mental Hyg irked othe itic event,	To Be C	17. Father's Name (First, Middle, Last) Max Bieber								Kornfel		ne)		
, Mary and 2 sho	atth and 27 is ma		19a Informant's Name/Relationship (Martin Bieber / 8	Type, Print) BON		19b Mailii 672	St.	ss (Street Andre	and Number WS P	er or Rura	i Route Number lana Lapai	n, NJ	) <del>77</del> 28	p Code)	
Baltimore, permit. Pages 1 at	nent of He int: If item iry or othe		20a. Method of Disposition 1   Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify		20b. P	Place of Dispo emetery, cre erside	natory or Cem	ame of other place etery	(e)		.8,2006	Saddle			
	Department of h Important: If its any injury or of once.		21. Signature of Funeral Service Licer	See Bry Ce	~						chinsky W. Washi			eral Home 20012	
Ph	nysician		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition	one cause on eac	h line.		ter the m	ode of dyin						Approximate Interval Between Onset and Death I hour	
20	Medical kaminer		resulting in death)	4.	as a conseq		4200	1011						1 Hour	
pel	lsit .	Examiner	Sequentially fist conditions, i. a. y, leading to inhediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or	as a curisaç	uence of)		-							
8760, cate be executed	physician and the burial-transit	dical Exar	that initiated events resulting in death) Last	c.  Due to (or	as a conseq	uence of):									
Box 6	ed by the attending ph detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		n 2 □ Feta tattime of d	Ideath 3	⊒Ectopic ⊒ Other (	pregnancy specify)					ate of deliverable	very Day Year	
S, P	6 9	þ	Part II. Other significant conditions of Acute Cholecyst		h but not res	ulting in the u	inderlying	cause giv	en in Part I	l.		oacco use con os 2∏XNo		the cause of death?	
Vital Records, P.O sician: The law requires that the	cate has been si page 2 should l	Completed			-			-			24a. Was a autops perform 1 Yes 2	y ned?	Were aut prior to codeath?	opsy findings available ompletion of cause of	
of Vita Physician:	is certificate director, pag	Be	25. Was case referred to medicat examiner?	Hospital:				Oth	er		Check only on	9)			
O E	듣쿊	n: To	1 ☐ Yes 2 ☐ No  27. Manner of Death	28a. Date of		28b. Time o		28c. Injur	y at		me 5 Reside 28d. Describe ho			ify)	
Division I or Attending	ter death. irector: After n by the funer.	Certification:	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not b 4 Homicide determined	28e. Ptace of			M reet, facto	1 🗆	Yes 2	-	28f. Location (St. City or Town		ber or Rui	ral Route Number,	
D Hospitel c	within 24 hours after death To the Funeral Director: completely filled in by the	edicai Cer	29a. Certifier	niner: On the bas	s of examina	owledge, deat	h occurre	d at the tin	ne, date ar pinion, dea	nd place, ath occurr	and due to the ca	iuse(s) and mate and place.	anner as and due	stated.	
o the	ro the comple	Med	29b. Signature and title of certifier	and manne	r stated.		2	9c. Licens	e number		2	9d. Date signe	ed (Month	, Day, Year)	
) [	5		1 Ander	leine	cat	2		D0036	5716			Oct. 1	7, 20	006	
***			30. Name and address of person who Andrew Kundrat,	completed cause 6121 Mon	of death (ften	n 23a) (Type, Rd., F	Print)	ille,	, MD :	20852	2				
	Sta Regist		31. Date filed (Month, Day, Year)	2006 32.8	istrar's Signa	ture L	bart	,						-	

		1 - For State Registrar	ate of Marylar		artment rtificate				giene Reg. No	200c	34855
Physici		1. Decedent's Name (First, Middle, Last) RICHARD MURRAY	BAXTER					2. Date of De. Month Octobe		, 2006	3. Time of Death 12:55P M
/Medio Examir		4a. Facility Name (If not institution, give street 9213 Hummingbird Ter					ocation of Dea		4c.	County of Death	ו
Funeral		Social Security Number     6. Sex	7. Age (In yrs.		If Under 1	Year	If Under 24 Hr Hours Mir		1	_	nplace (State or Foreign untry) W York
Director		Usual Residence of Decedent	00	Yrs.				Mar. 2	/, 1	946 Ne	
Maryla a-f shov	ctor	Md. 10b. County  Montgomery		y, Town or Lo .thersb							10d. Inside City Limits 1 ☐ Yes 2 🎇 No
with the	Dire	10e. Street and Number 9213 Hummingbird Ten	rrago		10f. Zip 0	2087	70		_	zen of What Co	•
36 rs efter deeth r, or Items 23 commer mus	by Funeral Director	11. Marital Status 12. W All I Never Married 2 🕅 Married I If	/as Decedent Ever in U med Forces? XIYes 2 □ No 190 Yes, Give ear or Dates: 190	65-	Was Decede If Yes, specif	nt of Hisp ly Cuban,		Specify Yes or No- rto Rican, etc.)	-	14. Race - Amer Black, White Specify: B1a	ncan Indian, a, etc.
Baltimore, Maryland 21215-0036 pendit. Pages 1 end 2 should be filed within 72 hours effer deeth with the Maryland Depertment of Health and Mental Hygiene. Important: If Itsm 27 is marked other than "natural", or Items 23s or 28s-f show any Injury or other traumstic svent. The Medical Examinar must be notified at once.	Completed t	15. Decedent's Education (Specify only highest grade com	1	16a. Deced (Give life.	dent's Usual kind of work DO NOT use ol Tea	done dui retired)	ring most of w	prking	16b. Ki	nd of Business/I	ndustry y County
yland 2 ould be filed a Mental Hygie arked other stic svent.	To Be Co	17. Father's Name (First, Middle, Last) Theodore Baxter	JT				8. Mother's Na	ame (First, Middle, Andrews			noois
Mar nd 2 sho alth and 27 is m r traum		19a. Informant's Name/Relationship (Type, Po Rosa M. Baxter (Wife)						<i>Gaithe Gumbe</i> . Gaithe	-		
altimore, mit. Pages 1 en pertment of Heal portant: If Itsm ?		20a. Method of Disposition 1   ↑ Burial 2 □ Cremation 3 □ Remov		Place of Dispo emetery, crer te of I	sition (Name natory or oth	e of ner place)	0ct	Date : 18,	20c. Lo	cation - City or	Town, State
Baltin permit properties Depertme Important any Injury		4 Donation 5 Other (Specify)  21. Signature of Funeral Service Licenses	Gal	22	2. Name and	Address	of Facility De	Vol Fune	ral	Home	ing, Md. Md. 20877
Physician /Medical Examiner	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Glio Blast Due to (or as a ourseq	h. Do not ent  Oma Mu  uence of):	er the mode	of dying,					Approximate Interval Between Onset and Death Months
J. BOX 68760, e death certificate be executed the ettending physicien and ned for use as the burial-transit	Physician/Medical Exa	Cause (Disease or injury that initiated events resulting in death) Last  C. Due to (or as a consequence of):  d.   IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1									very Day Year
dS, P.O. I	þ	9 ☐ Unknown  Part II. Other significant conditions contribut	ing to death but not res	ulting in the u	nderlying cau	use given	in Part I.				the cause of death?
VITAI RECORDS, P.O relater. The law requires that the secrificate has been signed by the lirector, page 2 should be detached.	e Completed	OF Wassers and an extensive section							med? 2 No	24b. Were aut prior to o death? 1 🗆 Yes	opsy findings available ompletion of cause of
of VIII hysicle his certi	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 🕅 No Hospita	1   Inpatient 2	ER/Outpatien	t 3 DOA	Other		ath <i>(Check only o</i> Home 5 <b>X</b> Resid		☐Other (Spec	ify)
VISION Of VITA Attending Physician: or deeth. sctor: Atter this certific by the funeral director,	ation:	27. Manner of Death  1 XNatural 5 Pending 2 Accident investigation	a. Date of Injury (Month, Day Year)	28b. Time of Injury	M 280	c. Injury a Work?	t s 2 □ No	28d. Describe h	iow injury	occurred	
2 2 3 2 3	Certification:	3 Suicide 6 Could not be determined 284	e. Place of Injury - At he building, etc. (Specif	ome, farm, str	eet, factory,	office		28f. Location (S City or Tow	street and m, State)	d Number or Rui	al Route Number,
To the Hospital within 24 hours e To the Funeral I	edlcai (	29a. Certifier (Check only one)  1 Certifying Physician 2 Medical Examiner: C	To the best of my kno on the basis of examina and manner stated.	wledge, death tion and/or inv	n occurred at vestigation, in	the time, n my opin	date and place ion, death occ	e, and due to the o urred at the time, o	ause(s) date and	and manner as place, and due	stated. to the cause(s)
	Me	29b. Signature and title of certifier	0 m.D		Ì	License n				ober 16,	
10+1		30. Name and address of person who complet	red cause of death (Item	23a) (Type,	Print)			01=====================================			
Sta Registr		Dr. Chitra Rajagopal  31. Date filed (Month, Day, Year)  OCT 18 2006	32 Registrar's Signa			11111	<b>у</b> ν ν ν	Olney, M	10. 2	20032	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Mariya Isakovna BAKALEYNIK October 2006 /Medical 12:00p 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery

9. Birthplace (State or Foreign Country) Rockville Shady Grove Adventist Hospital If Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Day, Year) Age (In yrs. last birthday) **Funeral** Months 1 □ M 2**X**□ F Days Director 216-47-4525 74 23. 1932 Ukraine Usual Residence of Decedent r 28a-f show notified at 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits Director 1 ☐Yes 2√☐No Maryland Montgomery Gaithersburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? pe must Funeral 17060 King James Way #322 20877 United States Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status American Indian Black, White, etc. traumatic event, the Medical Examiner 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2X Married 1 ☐ Yes 2 No þ Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) pormit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any Injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) Medicine 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 Isak Naumovich Shamis Lyubov Yakovlevna Felshstein 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Galina Goryacheva, Daughter 14 E. Darby Court, Gaithersburg, MD 20878 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1X Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Judean Memorial Gardens 10/06/06 Olney, MD 21. Signature of Fune at Service License 22. Name and Address of Facility Torchinsky Hebréw Funeral Home 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

| Immediate Source (Fig.) | 20012 Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) RENAL DISEASE 6 DAYS /Medical Due to (or as a consequence of): Examiner 6 DAYS SEPSIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 4☐Pregnant at time of death 1 ☐ Yes 2 X No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an was autopsy performed? 2 □ No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐**X**npatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2X No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of Certification: 28d. Describe how injury occurred 5 ☐ Pending investigation 1 🛛 Natural 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

and Box 68760 nding physician Ö Records, The Vital Physician: 0 Attending Division I or Attend after death Director: /

the Maryland

Baltimore, Maryland 21215-0036

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or Items 23a

natural

the burial-trans use as signed by the ar the within 24 hours a

1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year)

P. KURUVILLA, M) D 46187 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

OCTOBER 24, 2006

<u> Ajit P. Kuruvilla, M.D., 11125 Rockville Pike #208, Rockville, MD</u> 31. Date filed (Month, Day, Year)

State Registrar

Medical

26 CCT



State of Maryland / Department of Health and Mental Hygien 2006 34857 For State Registra Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Month **Physician** EARL EUGENE BREEDEN October 22, 11:06 2006 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Washington 103 Harvard Road Hagerstown If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Dec.5,1930 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5 Social Security Number **Funeral** Hours Months 1⊠M 2□F Maryland 75 Yrs. 215-26-8068 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits with the Maryland 10b County 10a State ir than "natural", or iteme 23a or 28a-f ahow the Medical Examiner must be notified at 1 Yes 2 No Maryland Washington Hagerstown Directo 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 103 Harvard Road 21740 Funeral filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ⊠ Yes 2 □ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: white Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) electrical sales wholesaler Pages 1 and 2 should be filed with ment of Health and Mental Hygie tent: if item 27 is marked other toury or other traumatic event. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Benjamin Wesley Breeden Letha Middlekauff မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 103 Harvard Road, Hagerstown, Md. 21740 Carrie Breeden - wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Depertment of important: if any injury or once. Rose Hill Cemetery 10/26/06 Hagerstown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility MINNICH FUNERAL HOME 21. Signature of Funeral Service Licensee 415 E.Wilson Blvd., Hagerstown, Md. 21740 estal tred IN 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each lines. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** e ci /Medical Due to (or as a consequence ol): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner physician and s the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Records, P.O. Box 68760, Physician/Medical use as the attending I for use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23h Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown δ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Š 1 Tyes 2 × No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital Physician: : After this certification a funeral director. 25. Was case referred to medical examiner? 26. Place of Death | Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 2 ER/Outpatient 3 DOA 1 Inpatient မှ this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death To the Hospital or Attanding Pt within 24 hours effer death.
To the Funaral Director: After the completely filled in by the funeral Certification; Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) 4 T Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of gertifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) OPEL CT, Hate S'EWAM 21740 111 31. Date filed (Month Day Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

			For State Registrar	State of Marylar		artment rtificate			d Mental F	lygiene Reg. No	900	6 31	+858
	Physici /Medic		1. Decedent's Name (First, Middle, Las	L.		Bar	+16	<u>.</u>	2. Date of Month		y Ye 20 20		ne of Death +6 A M
	Examin			PRINS HOS		Bo	$i + l_{x}$	ocation of E	city	1	County of C Balti	Death .more	
	Funeral Director		5. Social Security Number 216-40-7412  Usual Residence of Decedent	-57	1ast birthday) 53 Yrs.	If Under	Days	Hours	Min. 8. Date of (Month)  Jan	Day, Year)	943	Birthplace (St. Country) D.C.	ate or Foreign
	Maryland f show	or	10a. State 10b. County PA Frank		y, Town or Lo Wayr	nesbor	ю						de City Limits Yes 2XNo
	with the hard or 28a-	Direct	10e. Street and Number 10730 Old For			10f. Zip (	Code	7268		10g. Cit	izen of Wha	,	
036	s 1 and 2 should be filed within 72 hours after deeth with the Maryland I Heelih and Mental Hygiene. I Heelih and Mental Hygiene. Item 27 is marked other than "natural; or itsms 23a or 28a-f show other traumatic svent, the Medical Examiner must be notified at	by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 □ Yes 2 ☒No If Yes, Give Year or Dates:	ĺ	Was Decede If Yes, speci 1 Yes 2	ent of His rfy Cuban		? (Specify Yes or Puerto Rican, etc.)	No-	14. Race - /	American India White, etc. White	n,
21215-0036	filed within 72 ho Hygiene. other than "natur ant, the Wedical	Completed	15. Decedent's Et (Specify only highest gra Elementary/Secondary (0-12)	(ucation de completed) College (1-4or 5+)	(Give	dent's Usual kind of work DO NOT use	k done du e retired)	ring most of			ind of Busin	ess/Industry	
Maryland 2	S should be filed and Mental Hygid is marked other sumatic sysut, it	To Be C	17. Father's Name (First, Middle, Last) Theodore Tritl					18. Mother's	Name (First, Mid is Campb	dle, Maiden			
	Heelth and I sho tam 57 is mater treums	18	19a. Informant's Name/Relationship (  R. Glenn Bartle  20a. Method of Disposition	husband	10	730 0	ld F	orge 1	Rd., Way Date	nesbo	co, PA		te
Baltimore,	permit. Pages 1 a Depertment of Hee Important: If item eny injury or othe		1 Burial 2 Tremation 3 C 4 Donation 5 Other (Specification 2). Signature of Funeral Service Licer	"Cr	Place of Dispondent Place	ium 2. Name and	d Address	of Facility (	/25/2006 Grove-Bo . Waynes	werso	x Fune	ral Hor	ne, Inc.
200	Physician /Medical Examiner	er	23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate	a. Due to (or as a consection)	nyelequence of):	ter the mode	of dying	such as ca	rdiac or respirator	<u>-</u>		Approx	imate I Between and Death
,8260,	The law requires that the death certificate be executed the been signed by the attending physicien and sage 2 should be deteched for use as the burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a consect	quence of):								
P.O. Box 6	that the death certifica ed by the attending ph deteched for use as th	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	23c. If yes, outcome of pregnative birth 2 ☐Fete 4 ☐ Pregnant at time of c	al death 3	∃Ectopic pre □ Other (spe					23d. Date of Month	f delivery Day	Year
	w requires that been signed b should be det	þ	Part II. Other significant conditions of	ontributing to death but not res	sulting in the u	inderlying ca	iuse giver	n in Part I.		id tobacco	_	te to the cause	
of Vital Records,		Completed							1 □ Y€	utopsy erformed? s 2 🔀 No	prior		of cause of
	ding Phys h. After this funeral di	ition: To Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☑ No  27. Manner of Death 1 ☒ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	ER/Outpatier 28b. Time o Injury		A Other Bc. Injury Work	4 ☐ Nursi	ng Home 5 F	esidence		Specify)	
Division	2 2 2 2	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Special	ome, farm, st	reet, factory,	office			n (Street ar Town, State		or Rural Route	Number,
	To the Hospitel of within 24 hours of To the Funeral D completely filled in	edical	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	ysician: To the best of my kno niner: On the basis of examina and manner stated.	owledge, deat ation and/or in	h occurred a vestigation,	it the time in my opi	, date and p nion, death	place, and due to occurred at the tir	the cause(s ne, date and	) and manne d place, and	er as stated. due to the cau	ıse(s)
	To To Com	×	29b. Signature and title of certifier  Principle  By	astianed, Hed	ical Do		License		)		-	fonth, Day, Ye.	
SH	-10	,	30. Name and address of person who Priscilla Brastiana	s The Johns L	m 23a) (Type,	Print)	pital	,6001	Jouth Wa	ste St	reet,	Baltin	nove and 21205
1	Sta Registi		31. Date filed (Month, Day, Year)	32. Registrar's Signa	ature	herte)	,					3	

DHMH 17 Rev 1/2001

			For State Registrar	State of Marylar			nt of Heate of De		Mental Hy	giene Reg. No.	006	34859
			Decedent's Name (First, Middle, Last	st)					2. Date of De			3. Time of Death
Н	Physicia		Helen M. Cale	emine					Month	233	Year	11:58 A.M.
	/Medic Examin		4a. Facility Name (If not institution, give			4b. City	Town, or Lo	ocation of Dea	th	4c. Co	ounty of Death	
	- Admin	٠.	LIMUS - BRAG	HOCK CAN	1PUS	10	imbe	Rlar	nd	+	AlleGA	MA
	Funeral		5. Social Security Number 6. S		last birthday	) If Unde		Under 24 Hrs Hours Min	8. Date of Bi	rth av. Year)	9. Birthr	place (State or Foreign
П	Director		213-12-9301	<sup>□ M 2</sup> <b>3</b> 86	Yrs.	Worters	Days	TIOUTS TOTAL	July	YO 192	20 Mai	ryland
	p ,		Usual Residence of Decedent  10a. State 10b. County	100 0	ty, Town or L	conting					Т.	Od. Inside City Limits
	aryla sho	5	MD Allegan		stbur							1 ☐ Yes 2X No
	Ra-f	Director	10e. Street and Number	y PLC	JSCDUL		p Code	_		10a Citizor	n of What Cour	atms?
	with	ក់	12310 Upper Geor	raes Crook Pá	l CM		.532					my:
	ss 23	Funerai	11. Marital Status	12. Was Decedent Ever in L				anic Origin? (	Specify Yes or N		SA Race - Americ	can Indian.
	ter d	E	1 Never Married 25 Married	Armed Forces? 1 ☐ Yes 2 ☐ No					Specify Yes or Note (Note 1)		Black, White,	
336	al', or	β	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give A Year or Dates:		1 🗆 Yes	2 <b>△</b> No 3	Specify:		Sp	pecify:	√hite
ğ	within 72 hours after death with the Maryland ene. than "natural", or Items 23a or 28a-f show ta Madical Examinar must be notified at	Completed	15. Decedent's Ed		16a. Dece	edent's Us	al Occupation	on	diaa	16b. Kind	of Business/In	dustry
2	hin 7	ple	(Specify only highest gra	College (1-4or 5+)				ing most of wo	irkiisg			
7	gien gien er th	Con	11		Hon	nemak				<u> </u>	wn Hor	ne
g	al Hy	Be	17. Father's Name (First, Middle, Last)				18	3. Mother's Na	me (First, Middle	, Maiden Su	mame)	
<u>8</u>	Menid &	2	Julius Budries						es (Ger			
Maryland 21215-0036	2 sho		19a. Informant's Name/Relationship ( Julio Calemine	Type, Print) Spouse		-			ural Route Numb	-		
2	and leeith m 27							eorges	Date			stburg, MD
0	F of H		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐		Place of Disp cemetery, cre	ematory or	other place)	1	Date		tion - City or To	
Ē	Pa tant:		4 Donation 5 ☐ Other (Specif		unset	Memo	rial G	ar Oct	26 06		berlan	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heelth and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show injury or other traumatic event, Itra Madical Examinat must be notified at ance.		21. Signature of Funeral Service Licer	Ja Pay Ty					afer Fu ., LaVal			e, PA
			23a. Part1./Enter the disease, or com shock, or heart failure. List only	plications that caused the dea							21302	Approximate
			shock, or heart failure. Wist only Immediate Cause (Final	21			1 +	*	. ,			Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. Due to (or as a conse	zlia!	10	Tarella	en				One hour
	Examiner			Athen	C(10)	rotio	6	141617	Arten	1 Dis	ease	10 Yays
		er	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a consec	quence of):			, and	11/1/		.,,	
9.	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	C								
7	exec en an rial-tr	Exa	resulting in death) Last	Due to (or as a consec	quence of):							
8760,	ate be executed hysicien and the burial-transit	dicai	•	d								
Ö	ng ph as th	Jed	IF FEMALE:									
Вох	th ce tendii r use	an/l	23b. Was decedent pregnant	23c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Fet		□Ectopic	pregnancy			230	Date of delive     Month	ery Day Year
П.	e dea he at hed fo	sici	in the past 12 months? 1 Yes 2 No	4☐Pregnant at time of a 9☐ Unknown	death 5	Other (s	pecify)				MOHUI	Day 19a1
Р. О.	Attending Physician: The law requires that the death certific r death.  sector: After this certificate hes been signed by the attending p by the funeral director, page 2 should be detached for use as by the funeral director, page 2.	Physician/Me	9 Unknown					in Donal	22a Did	tobosos uso		he course of death?
Ś	res th	by	Part II. Dther significant conditions of	tral fib	15		cause given	m ran I.		Yes 2		he cause of death?
oro	w require been signature	Completed	1		1/4/	rion				103 200		
ec	law les b	nple	Demanti	4					24a. Was	psy	prior to co	ppsy findings available impletion of cause of
<u> </u>	The page	Con							1 ☐ Yes	ormed2 2 No	death? 1 ☐ Yes	2 🗆 No
/ita	cian: ertific	Be	25. Was case referred to medical examiner?	11			T .	6. Place of De	eath (Check only	one)		
<u></u>	hysi this c	မ	1 Tes 2 No		ER/Outpatie				Home 5 ☐ Res		<u>-</u>	(y)
Ē	ing F	<u></u>	27. Manner of Death 1. ■ Natural 5 □ Pending	28a. Date of Injury (Month, Day Yeer)	28b. Time Injury		28c. Injury at Work?		28d. Describe	now injury o	ccurrea	
Sic	tend death tor: the f	cat	2 Accident investigation 3 Suicide 6 Could not b		1	M		s 2 No	29f Location	(Ctroot and A	humbar or Rus	al Route Number,
Division of Vital Record	after a Direction by	Certification:	4 ☐ Homicide determined	28e. Place of Injury - At I building, etc. (Spec		treet, facto	гу, опсе		City or To	wn, State)	umber of Hurs	ar moute (variber,
_	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funerel Director: After this certificate hes completely filled in by the funeral director, page 2		29a. Certifier Certifying Pt	ysician: To the best of my kn	owledge, dea	ath occurre	at the time,	date and place	e, and due to the	cause(s) an	d manner as s	tated. +
	n 24 n 24 he Fu	edical	(Check only 2 Medical Examone)	niner: On the basis of examin and manner stated.	ation and/or i	nvestigatio	n, in my opin	ion, death occ	urred at the time	, date and pa	ace, and due to	o the cause(s)
	To t COM	Σ	29b. Signature and title of conflier	6100			c. License n				signed (Month,	
			1/1/4/	Ul Ca	and a	ź	000	211	189	00	t. 23	2006
	3		30. Name and address of person who	completed cause of death (Ite	m 23a) (Type	Print)	/)	1	1	/	,	2006
	7		Thomas	1. Veulin	MD;	20	Doy	9/41	HUC,	Long	a Conta	2, 19 2153
	Sta Registr		31. Date filed (Month, Day, Year)	32. Aegistrar's Sign	ature	OBSEL.	*					

DHMH 17 Rev 1/2001

ORIGINAL

			For	State of Ma	ryland	d / Depa	artmen	t of H	ealth a		,		gibic.	01.061
			1 - State Registrar			Cer	tificat	e of L	Death		2. Date of Dea	leg. Ne?	106	34861
	Physicia /Medic		1. Decedent's Name (First, Middle, Last, Ruth Hill Cano								Octobe:		2006°	3. Time of Death 1:03 A M
	Examin		4a. Facility Name (If not institution, give 5820 Genesis Lane,				, .	Town, or	Location o	f Death			unty of Death	
	Funeral Director		Social Security Number 6. Set		(In yrs. Is	ast birthday) 3 Yrs.		1 Year Days	If Under: Hours	24 Hrs. Min.	8. Date of Birt (Month, Day Aug • 23			lace (State or Foreign try) York
	D .		Usual Residence of Decedent  10a, State 10b, County		10c City	r. Town or Lo	cation						1	0d. Inside City Limits
	Maryla f eho	jo	Maryland Frederic	k	,	Freder							,	1 □Yes 2 No
	or 28a or 28a or 28a	Directo	10e. Street and Number			110001	10f. Zip	Code				10g. Citizen	of What Coun	itry?
	23a c	alD	5820 Genesis Lane,	Apt. 512			2	1703	3			Uni	ted St	ates
	er des lteme	Funeral		12. Was Decedent E Armed Forces?		S. 13. V	Was Deced f Yes, spec	ent of Hi	spanic Orig n, Mexican	gin? (Spe , Puerto	ecify Yes or No- Rican, etc.)	14.	Race - Americ Black, White,	
20	be filed within 72 hours after death with the Maryland Hygiene. A Hygiene and other than "natural", or items 23s or 28s-f show event, it a Medical Examinar must be notified at	by	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	0		1 □ Yes	2XX No	Specity:			Spi	ecify: Whi	te
9500-61212	72 ho	Completed	15. Decedent's Edu (Specify only highest grad	cation e completed)		16a. Deced	tent's Usua kind of wo	al Occupa	ation luring most	of worki	ng	16b. Kind o	of Business/Inc	dustry
7	within 72 ene. then net	Juno	Elementary/Secondary (0-12)	College (1-4or 5+	+)		cher	se retired,	)			Educ	ation	
ק פ	e filed v other i	Be Co	17. Father's Name (First, Middle, Last)			ıca	CHET_		18. Mothe	r's Name	(First, Middle,			
	should be nd Mental marked o martic eve	To E	Alfred E. Hill								ice Boy			
Maryland	permit. Pages 1 end 2 should b Deperment of Health and Ments Important: If item 27 is marked eny injury or other traumatic e once.		19a. Informant's Name/Relationship (T) Matthew Cano / Son			1	-				<i>d Route Numbe</i> Stin, TX			Code)
ē,	s 1 en if Heall item 2 other		20a. Method of Disposition		20b. Pl	lace of Dispo					Date 18,		on - City or To	wn, State
Ē	Page ment c ant: if ury or		1 ☐ Burial 2 【X Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	lemoval from State	-{	thaver			-			Frede	rick, M	laryland
Baltimore,	permit. Depertimport Import eny inj		21. Signature of Funeral Service vicens	50	-	R R	Name ar estha	d Addres	Funer	al S	Services	s, Skk	ot Cod	y P.A.
			23a. Part1. Phier the disease, or composhock, or heart failure. List only of	cations that caused	the death						Hwy. Fi		ck, MD	Approximate
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)		na	nly.					Princ			Interval Between Onset and Death
	Examiner	_	Sequentially list conditions	Due to (or as a										
	uted	Examiner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	`	t consequ	rence or):								
/60,	ate be executed nysicien and he burial-transit	Exa	resulting in death) Last	Due to (or as a	consequ	ience of):								
6876	icate b physic s the b	dlcal		d										
ROX	leath certificat attending phy I for use as th	ın/Me	230. Was decedent pregnant	23c. If yes, outcome o			Textonio e					23d.	Date of delive	ry
o.	that the deat ned by the attr detached for	Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at t			Ectopic pr Other (sp						Month	Day Year
rds, P	The law requires that the death certifica tte has been signed by the attending ph bage 2 should be detached for use as th	þ	Part II. Other significant conditions co	ntributing to death bu	t not resu	ulting in the ur	nderlying c	ause give	n in Part I.			bacco use d es 2ДN		e cause of death? ably 4Unknown
Records,	The law re te has be age 2 sho	Completed									24a. Was autop	sy med?	tb. Were autor prior to condeath?	osy findings available npletion of cause of
Vital		Bec	25. Was case referred to medical examiner?							of Death	(Check only o	1		
ö	Physi rthis c ral dire	- 1º	1 ☐ Yes 2 ☐ No  27. Mannar of Death	lospital: 1 ☐ Inpatien 28a. Date of Injury		ER/Outpatien		Bc. Injury	4 🗀 140		me 5d Resid 28d. D. cribe h			)
0	nding I ath. r: After e funer	atlon	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day	Year)	Injury	м	Work	?ি Yes 2⊡I			,,		
Division	Nospital or Attendi 24 hours after death. Funerel Director: A etely filled in by the f.	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inju- building, etc.			eet, factor	r, office		1	28f. Location (S City or Tow	treet and Ni n, State)	umber or Rura	l Route Number,
	To the Hospital or Attending Physician: within 24 hours after death of the Funerel Director: After this certific completely filled in by the funeral director.	Medical C	29a. Certifier Cartifying Phy (Check only one) 2 Medical Exami	sician: To the best of nar: On the basis of and manner stat	examinat	wledge, death ion and/or inv	occurred vestigation	at the tim, in my op	ne, date an pinion, dea	d place, a	and due to the ded at the time, d	ause(s) and date and pla	manner as st	ated. the cause(s)
	To the within 2 To the complet	Σ	29b. Signature and title of certifier				290	. License	number			29d. Date si	gned (Month, I	Day, Year)
	1		PHUST	75				06	oul	7		101	18/6	
	5		30. Name and address of person who con Herman Shah.	mpleted cause of de	ath (Item		Print)	S Guz	5	N/	Fre	deri	CIC "	15 2/702
	Sta Registr		31. Date filed (Month, Day, Year)  OCT 2 0	2006 32. Redistra	r's Signat	ture	fee	1						

			For State Registrar	State of M	aryland / Depa <i>Cei</i>	artment of H			iene 9. kg. 006	34862
			1. Decedent's Name (First, Middle, Las	it)				Date of Death     Month	h Day Year	3. Time of Death
	Physicia /Medic		Lienchi Congtonnu						7, 2006	1:17a M
	Examin	er	4a. Facility Name (If not institution, give			·	Location of Death		4c. County of Deat	
			13714 Willow Tree			Rockvill If Under 1 Year	e If Under 24 Hrs.	0 D-4 (Dist	Montgome	
	Funeral Director		5. Social Security Number 6. S 215–29–9677	ex	ge (In yrs. last birthday) 96	Months Days	Hours Min.	8. Date of Birth (Month, Day, JUL 10.	Year) Co	hplace (State or Foreign untry) tnam
	D .		Usual Residence of Decedent					COL TO:	1710   120	
	arytar show	2	10a. State 10b. County		10c. City, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 🕅 No
	28e-1	Director	Maryland Montgom	ery	Rockvill	10f. Zip Code		10	Og. Citizen of What Co	
	with Se or		13714 Willow Tree	Dr		208	150		United St	•
	ieath ns 23	era	11. Marital Status	12. Was Decedent	Ever in U.S. 13.	Was Decedent of Hi If Yes, specify Cuba		ecify Yes or No-	14. Race - Ame	rican Indian,
36	be filed within 72 hours after death with the Maryland Hygiene.  I have the then "natural", or items 23e or 28e-f show of other then "natural", or items 23e or 28e-f show event, Ira Madical Examinar must be notified at	by Funeral	1 Never Married 2 Married 3 MWidowed 4 Divorced	Armed Forces' 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:	No	If Yes, specify Cuba 1 ☐ Yes 2 🏋 No	n, Mexican, Puerto Specify:	Rican, etc.)	Black, Whit	
Maryland 21215-0036	72 hou	ted	15. Decedent's Ec	lucation		dent's Usual Occupa		ina	16b. Kind of Business/	Industry
218	within 7 ene. then "r	Completed	Elementary/Secondary (0-12)	College (1-4or	life.	DO NOT use retired	)	ing		
2	led w lygier her th		17. Father's Name (First, Middle, Last)		Home	Maker	18. Mother's Name	(First Middle A	Own Home	
anc	t be findal helped of	Be C	Chuan Ung					Nguyen	naidon Camamo,	
IZ.	12 should be filed within h and Mental Hygiene. 7 is marked other then "traumatic event, It a Max	수	19a. Informant's Name/Relationship (	Type, Print)	19b. Maili	ng Address (Street a			City or Town, State, 2	Zip Code)
Ma	s 1 and 2 should Health and Men Item 27 is marke other traumatic		Chau Kim T. Le, D	aughter	13714	Willow I	ree Dr	Rockvil.	le. MD 20	850
ore,	es 1 a of Hei fitem fothe		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☑	47	20b. Place of Dispo cemetery, cre	osition (Name of matory or other plac	θ)	Date 2	20c. Location - City or	Town, State
Ē	Page ment		'4 □ Donation 5 □ Other (Specify		Fairfax l	Memorial	F/H 10/1	8/2006_E	Fairfax, Vi	irginia
Baltimore,	permit. Pages 1 and 2 s Department of Health an Importent: If item 27 is any injury of other trau		21. Signature of Funeral Service Con		F	2. Name and Addres 'airfax Me '902 Bradd	morial F	uneral H	ome x. VA 2203	2
	7.11		23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that cause one cause on each	d the death. Do not en					Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	a Cerebro	ovascular A	ccident				Onset and Death
	/Medical Examiner		resulting in death)		s a consequence of):					2
Ь		e.	Sequentially list conditions,	b. Due to (or as	s a consequence of):					
	uted d ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events							
0,	an an	Еха	resulting in death) Last	Due to (or as	s a consequence of):					
8760,	requires that the death certificate be executed seen signed by the attending physician and hould be detached for use as the burial-transit	dlcal		d						
9	ertifica sing pl	a a	IF FEMALE:	O2a If was autoom	a of programmy					
Вох	leath certific attending pl	lan/	23b. Was decedent pregnant in the past 12_months?		2 Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of de Month	Day Year
o.	that the death cer ed by the attendir detached for use	Physician/M	1 ☐ Yes 2 ØNo 9 ☐ Unknown	9□ Unknown						
Δ.	s that ned b e deta	by Pt	Part II. Other significant conditions	ontributing to death	but not resulting in the u	inderlying cause give	en in Part I.	23e. Did tob	pacco use contribute to	the cause of death?
rds	w requires t been signe should be	ed b	Hypertension					1 □ Ye	as 2.MINo 3.∏Pr	robably 4 Unknown
Records,	aw s L	Completed	Myelodysplacia					24a. Was ar autops	y prior to	utopsy findings available completion of cause of
R	The ate	Com						perform	ned? death?	
Vita	Physicien: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:		oth	26. Place of Deat			
of Vital	S = D	T.	1 ☐ Yes 2 ☐XNo  27. Manner of Death	1 ☐ Inpat	ient 2 ER/Outpatie	III JUDON	4   14013/119 110		ence 6 Other (Spe ow injury occurred	cify)
on	Attending Indeath.  Sector: After by the funer	tlon	1 Natural 5 Pending 2 Accident investigatio	(Month, D	ay Year) Injury	Wor	k? Yes 2 □ No		. ,	
Division	i or Attendir after death. Director: At in by the fu	Certification:	3 Suicide 6 Could not be determined	200. Flace UI II	njury - At home, farm, st tc. (Specify)	reet, factory, office		28f. Location (St. City or Town	reet and Number or Ri n, State)	ural Route Number,
_	To the Mospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	Medical Co	29a. Certifier 1 (Check only one) 1 Medical Example 1	nysician: To the bes niner: On the basis and manner s	t of my knowledge, deal of examination and/or in tated.	th occurred at the tin evestigation, in my o	ne, date and place, pinion, death occur	and due to the ca red at the time, da	ause(s) and manner as ate and place, and due	s stated. e to the cause(s)
	To the within To the	Me	29b. Signature and title of certifier	1		29c. Licens	s number	25	9d. Date signed (Mont	h, Day, Year)
			hand /	21 /hr.	ll	D3599	16		10/17/2006	
	0	9	30. Name and address of person who	completed cause of	death (Item 23a) (Type			THE REAL PROPERTY.	THE PROPERTY OF THE PARTY OF TH	
			Linda M. Burrell,		University		00 Wheat	ton, MD	20902	
	Sta Registi		31. Date filed (Month, Day, Year)  OCT 18 20	06 Regis	trar's Signature	de				

DHMH 17 Rev 1/2001

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death October 17, **Physician** 2006 Franklin Cohen 1:10 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Montgomery Hebrew Home Of Greater Washington Rockville If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 10XM 2□ F Director 86 043-14-6785 31, 1919 Connecticut Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heath and Mental Hyglene.

and: If Item 27 is marked other than "naturel; or Items 23a or 28a-f show the traumatic event, the Medical Exemples multiple at any or other traumatic event, the Medical Exemples multiple at 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 ☐ No Montgomery Bethesda Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5225 Pooks Hill Road, #604-S 20814 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 XNo 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: white δ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Coltege (1-4or 5+) Salesman Paper Industry 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Mary Friedman Samuel Cohen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5225 Pooks Hill Rd., #604, Bethesda, MD 20814 Lillian R. Cohen / wife 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 Burial 2 Cremation 3 Removal from State permit. Page Deportment o Important: If any injury or once. Cedar Park Cemetery 10/19/2006 Paramus, New Jersey 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility
Louis Suburban Chapels 13-01 Broadway, Fair Lawn, NJ 07410 M00956 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final respiratory Physician hours disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner movary Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events attending physician and for use as the burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Yea Month Day 4 Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown ģ been signed t should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No After this certificate has funeral director, page 2 autopsy performed 1 Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No P 1 Inpatient 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural Injury To the Hospites C. within 24 hours efter death.
To the Funersi Director: Aft 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD who completed cause of death (Item 23a) (Type, Print) 30. Nan and address of perso Montrose

State

Registrar

Kuhn

18

2006

31. Date filed (Month, Day, Year)

6121

32 Registrar's Signature

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2. Soud Score Nestere   Size   Sax		/Media	cal	4a. Facility Name (If not institution, give	street and number)		4b. City, T					4c. County	of Death		P A M
100   100		Euperal				last birthday)	If Under 1				8. Date of Birt	th			or Foreign
The same of the finance of the finan					D		Months	Days	Hours	Min.	Month, Da May 27	, Year) , 1938	Cour	ntry)	or r oraigir
To Due to (or as a consequence of the county)  To Due to (or as a conseq		and and			10c. Cit	ty, Town or Lo	cation						1	10d. Inside C	ity Limits
To Due to (or as a consequence of the county)  To Due to (or as a conseq		Maryl	tor	Maryland Washing	gton Ha	gersto	wn								•
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To Due to (or as a consequence of the county)  To Due to (or as a conseq	980	urs after de al', or item Exertiner	þ	1 ☐ Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give	1				gin? (Spe , Puerto	ecify Yes or No Rican, etc.)		ck, White,	etc.	
Physician Medical Examiner  Ph	5-0	72 ho	eted	15. Decedent's Ed	ucation de completed)	16a. Deced	dent's Usual	Occupat	ion irina most	of warki	ina	16b. Kind of B	usiness/In	dustry	
Physician Medical Examiner  Ph	121	within ane. then	dmo					retired)				har or	m ho	m o	
Physician Medical Examiner  Ph		illed Hygie other	e Co	17. Father's Name (First, Middle, Last)	0	Home	maker	1	18. Mother	r's Name	(First, Middle,			ще	
Physician Medical Examiner  Ph	ylan	Menta Menta mrked atic ev	To B	Robert Kenneth N	AcCarney				Ма	ry (	Gertrude	e Everly	7		
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Physician Medical Examiner  Ph	E O	Peges nent of int: if i			riemoval from State	-	-			10/2	7/06	Hagerst	own,	Mary1	and
Physician (Modical Examiner)  The control of the cause (Final Action of the cause of death of the cause of dea	Balti	permit. Departn Imports eny inju		21. Signature of Funeral Service Licen:	Mimus	/ /			of Facility	MI	NNICH F			Land 2	1740
Seption of the case of conditions of season of conditions of season of conditions of same of conditions of				23a. Part1. Enter the disease, or composhock, or heart failure. List only	olications that caused the death								Ī	Approximat Interval Bet	te tween
State    Sequentially list conditions cause. Entart Underlying Cause. (Disease or injury Cause.) (Dise				disease or condition	a Pulse	elen	Ge	elri	cal	1	Aclion	ty	14	Onset and i	Death
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Due to (or as a consequence of):    Due to (or as a consequence of):		7 -	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a conseq	uence of):	VI 4	OL	<i>)</i>	11 4 1	URIC	) [0 >/	DIM		
FFEMALE:   230. Was decedent pregnant in the past 12 months?   1   1   1   1   1   1   1   1   1		ecuted and transi	cami	that initiated events	· UNCE	DNTR	011	30	#	48	BRTE	NS(01	<u> </u>		
FFEMALE:   230. Was decedent pregnant in the past 12 months?   1   1   1   1   1   1   1   1   1	,60,	be ex Sician burial	al E		Due to (or as a conseq	uence or):									
The state of the s	9	tificate ig phys as the	ledic		d										
The state of the s	30X	ath cer tendin or use	an/N	23b. Was decedent pregnant			Ectopic pre	gnancy							
The state of the s		he dea	ysici	1 ☐ Yes 2 ☐ No		eath 5	Other (spec	crfy)				Мо	ntn	Day	rear
25. Was case referred to medical sexaminer?  10 yes 2		s that t ned by e deta	y Ph	Part II. Other significant conditions co	entributing to death but not res	ufting in the ur	nderlying cau	ıse given	in Part I.		23e. Did to	bacco use contr	nbute to th	e cause of c	death?
25. Was case referred to medical sexaminer?  10 yes 2	ords	equire en sig ould b	ted b	HISTORY OF #	HBPO HINAL	HOR	uc	AND	URY	SM,	1 U Y	'es 2□No	3 Prob	ably 4 🗆	Jnknown
26. Place of Death (Check only one)  27. Manyfer of Death 1	II Reco	The law rate hes be	Comple	HUPERTENSION	U, END ST	(AGB	RB	NAC	DIS	EK.	autop perfor	med3	prior to con leath?	noletion of c	available ause of
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State  State  Calculated up to PI(ALST D0063 396 10 23 06.  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  D Kurapaly 25   East Antietan I + .   try Md 21740  State  31. Date filed (Month, Day, Year)   32. Registrar's Signature	o	Phys ar this eral di	n: To	27. Manner of Death	28a. Date of Injury	28b. Time of			4 🔲 NUI					1)	
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State 31. Date filed (Month, Day, Vear) 32. Registrar's Signature		Vitt To	2	29b. Signature and title of certifier	One of HOSPITA	ALIST	29c.	License r	number			29d. Date signed	(Month, L	Day, Year)	
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State	51	1-3		Dr Kurapal	251 Eus	t Ant	retar	2	ft.		1100	MJ 2	174	0	
				31. Date filed (Month, Day, Year)	32. Registrar's Signa	ture	a. M. 2				7				

DHMH 17 Rev 1/2001

			1 - For State Registrar	State of Maryland			lealth and		-000	6 341	865
	Physic		Decedent's Name (First, Middle, Last)     RANDOLPH M. DAV	IS				2. Date of Death Month	Day,	Year ,	of Death
	/Medi Examir		4a. Facility Name (If not institution, give s	treet and number)		4b. City, Town, o	r Location of Deat		4c. County o		(3)
		4	317 S. STOKES STR				DE GRACE		HARI		
	Funeral Director		5. Social Security Number  224-52-4805  Usual Residence of Decedent	M 2□F 7. Age (In yrs. la	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	(Month, Day,		9. Birthplace (State Country) VIRGINIA	
	lanyland show		10a. State 10b. County	10c. City,	Town or Lo	cation				10d. Inside	City Limits
	or 28e-f s	Director	MARYLAND HARF	ORD		HAVRE DE	E GRACE				es 2 No
	th with the 23a or 2	al Dire	10e. Street and Number 317 S. STOKES	STREET		10f. Zip Code	21078	10	g. Citizen of Wi USA	hat Country?	
980	after dea or items	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 ☒ Widowed 4 □ Divorced	2. Was Decedent Ever in U.S Armed Forces? 120 Yes 2 □ No If Yes, Give Year or Dates:1956—6		Vas Decedent of H i Yes, specify Cuba ☐ Yes 2 ☐ No	ispanic Origin? (S in, Mexican, Puerl Specify:	pecify Yes or No- o Rican, etc.)	Black	- American Indian, , White, etc. BLACK	
2-0	72 hours "natural",	eted	15. Decedent's Educ (Specify only highest grade	ation	16a. Deced	ent's Usual Occup	durina most of wor	rkina 1	6b. Kind of Bus	iness/Industry	
21215-0036	within ene. then '	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		OO NOT use retired ECURITY	•		U.S. G	OVERNMEN	ידין
Maryland 2	should be filed within Mental Hygiene. marked other then metic event, I wall	To Be Co	17. Father's Name (First, Middle, Last)  JAMES DAVIS					ne (First, Middle, M			
ary	should I and Men is marke	-	19a. Informant's Name/Relationship (Type	ne, Print)	19b. Mailin	g Address (Street	and Number or Ru	ıral Route Number,	City or Town, S	tate, Zip Code)	11
Baltimore, M	0 0		MARY JACKSON / NT  20a. Method of Disposition  1 Durial 2 Cremation 3 Re 4 Donation 5 Other (Specify)	emoval from State	ice of Dispos metery, crem	STORM BRA sition (Name of latory or other plac UNITED C	е)	AIKEN, S Date 2 21/06 HA	oc. Location - C	ity or Town, State	
ST. JAMES UNITED CEM. 10/21/06 HAVRE DE GRACE, MARY  21. Signature of Funeral Service Licensee  1 Signature of Funeral Service Licensee  22. Name and Address of Facility  LISA SCOTT FUNERAL HOME, P.A.  552 LEWIS STREET, HAVRE DE GRACE, MD 2107											
Physician /Medical Examiner  23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  25a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  25a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  25a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  25a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  25b. Was decident pregnant in the past 12 months?  25c. If yes, outcome of pregnancy shock or heart failure. List only one cause on each line.  25c. Due to (or as a consequence of):											
O. Box 6	death certific e attending p id for use as	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	ic. If yes, outcome of pregnan  1 Live birth 2 Fetal of  4 Pregnant at time of dea	death 3□	Ectopic pregnancy Other (specify)			23d. Date Month		Year
rds, P	signed signed d be de	by	Part II, Other significant conditions con	ributing to death but not result	ting in the un	derlying cause give	en in Part I.		,	ute to the cause of	
Vital Records,	The ate h	Completed						24a. Was an autopsy performe 1 □ Yes 2	prio de	ere autopsy finding or to completion of ath? Yes 2 No	s available cause of
	Physicien: rthis certific ral director,	o Be	25. Was case referred to medical examiner?  1 ✓ Yes 2 ☐ No	ospital: 1 ☐ Inpatient 2 ☐ E	R/Outnatient	3□ DOA Othe		th <i>Check onlone</i> ome 5 Residen	o 6 □Othor	(Specify)	
ion of	ling After fune	atlon; T	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation		28b. Time of Injury	28c. Injury Work	at :? Yes 2 □ No	28d. Describe how			
Division	in Dir	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At hom building, etc. (Specify)	ne, farm, stre	et, factory, office		28f. Location (Stre City or Town.	et and Number State)	or Rural Route Nu	mber,
	To the Hospital within 24 hours a To the Funerel C completely filled	edical	29a. Certifier (Check only one) 1 Certifying Physics Medical Exemination (Check only one)	cian: To the best of my know er: On the basis of examination and manner stated.	ledge, death on and/or inv	occurred at the timestigation, in my op	ne, date and place pinion, death occur	, and due to the cau rred at the time, dat	se(s) and mann a and place, and	ner as stated. d due to the cause	(s)
	To t To t	Σ	29b. Signature and title of certifier	//		29c. License	number	290	. Date signed (i	Month, Day, Year)	
,			Bernoul J. Ja	un MU DME		120/4	1206	$\alpha$	DBER	18, 2006	
12	HVA		BERNARD J. YUKI	Inpleted cause of death (Item 2)  A M M M  32. Registrar's Signatu  06	23a) (Type, F	CHURCA	Ville K	O BEL	AIR F	4d 210	5-
	Sta Registr		31. Date filed (Month, Day, Year)  OCT 2 0 20	32. Registrar's Signatu	A A	medi			/		

Amended item 23a per physician; 10/23/06 cs

### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / De

epartment of Health and Mental	Hygiene	Ω	$\cap$	C
epartment of Health and Mental	Por No	U	U	O

					,	Ce	rtificate	of	Death		Reg. No.	U b	31	+866
Physicia	n	1. Decedent's Nan	ne (First, Midd		D: D 1	.1				2. Date of D	Day /	Year	2 11	ime of Death
/Medic		4a Engility Name	(If not institutio	Wesley I n, give street and n	Price Duck	worth			4b. City, Town, or L	OCTUS		200		00 [ 7
Examine	er	4a. Facility Name (						'			40. Cou	nty of Dea		
		5. Social Security I		Egle Nursing 6. Sex	T	la a t histoslav	If Under 1 \	/ear	Lonacon If Under 24 Hrs.		-46-		legany	O. 1. E .
Funeral Director		220-10-1	958	1,⊠ M 2□ F	7. Age (In yrs. 85	Yrs.		ays	Hours Min.	8. Date of Bi (Month, D June 0		9. 8	Mary	State or Foreig land
be filed within 72 hours after death with the Maryland tal Hygiene. d other than "natural", or Items 23a or 28a-f show event, if a Mcdical Examiner mast be notified at	_	10a. State	10b. County		10c. Ci	ty, Town or L	ocation				F4			side City Limits
Ba-f.	용	Maryland	A	llegany				L	onaconing				15	Yes 2□No
2 2 3	흦	10e. Street and Nu	ımber				10f. Zip Co	de			10g. Citizen	of What C	ountry?	
23a	ā		57 J	ackson Stree	t				21539			U.S	S.A.	
Items Iner na	Funeral Director	11. Marital Status 1 ☐ Never Mari		12. Was Dec Armed F	cedent Ever in U	J,S. 13.	Was Deceden If Yes, specify	t of H Cuba	lispanic Origin? (Sp an, Mexican, Puerto	pecify Yes or No Rican, etc.)	o- 14. F	Race - Am Black, Wh	erican Ind ite, etc.	lian,
ral', or	ক	3 Widowed		If Vac G	ive		1 ☐ Yes 2 🕅	No	Specify:		Spe	cify:	Wh	ite
natu	etec	(Spe	15. Deceder	it's Education st grade completed	)	16a. Dece	dent's Usual C	ccup	oation during most of world)	king	16b. Kind o	Busines	s/Industry	
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Mental H arked ott	Be	17. Father's Name		,					18. Mother's Nam			,		
smarke smarke umatic	ို			arles Wesley	Duckworth						rgaret Fis			
is me	Ø	19a. Informant's N	ame/Relations	ship (Type, Print)		19b. Maili	-		and Number or Ru		•			
Health iem 27 i other tra	- 1			h Blair - Dau					rton Drive, C					
Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, it a Medical Examiner must be muffied at once.		20a. Method of Dis 1 Marial 2 4 □ Donation	☐ Cremation	3 ☐Removal from		cemetery, cre	osition (Name of matory or other	r plac		Date October 18, 2006	20c. Locatio		Town, St , Mary	
artment of ortant: If its injury or o	-	21. Signature of Fi					g Memori 2. Name and A			2006	110	stourg	, iviai y	lanu
Departr Importa any inju		De Can	1.3.	Neken					Eichhorn-Mo st Main Stree					
hysician		23a. PartT. Enter t shock, or hea	the disease, or art failure. List	complications that only one cause on	caused the deat each line.	th. Do not en	ter the mode of	f dyin	ng, such as cardiac	or respiratory a	ırrest,		Appro Interv Onse	oximate al Between t and Death
Medical		Immediate Cause disease or condition	(Final	MA	ture o	414	pneum	on:	ia agonal				10	vilh
xaminer		resulting in death)		a		or as a conse							1	1 0
sit.	Examiner			- b cht	une o	reita	1100	ad	vanced al	zheimen	c's dis	ease	60	NB
attending physician and for use as the burial-trensit	хай	Sequentially list co	onditions,		Due to (d	or as a conse	quence of):						1: .	
ouria		Sequentially list co if any, leading to in cause. Enter Unde Cause (Disease or that initiated events	erlying	- Ud	ATP-1-	-a+1	her your	7-	17-1584-59-	•			4 4	rars
hysi the t	edicai	that initiated events resulting in death)	s Last	ŭ	Due to (c	r as a consec	juence of):							
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he at	Sic	Part II. Other signif	ficant condition	ons contributing to c	leath but not res	ulting in the u	nderlying caus	e giv	en in Part I.	23b. Did	tobacco use	contribut	to the c	ause of death
ed by the a	Physician									10	Yes 2∭ No	3 □ P	robably	4 🗌 Unknow
ந்த .	od be										an autopsy	24b.	Were aut	opsy findings
been si	Completed									perfo	ormed?		available completion of death?	prior to in of cause
ate has b	Ĕ										Van O'Van			OF N
		25. Was case refer		8						10	Yes 2 No	-	1 Yes	2L J No

spital or Attending Physician nours after death.
neral Director: After this certifi Division of Vi To the Hospital of within 24 hours at To the Funeral Discompletely filled in

examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Aursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Natural 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

29c. License number

30. Name and address of person who complete Vause of death (Item 23a) (Type, Print)

No und Manget 1 4 45 Hej 200

Qued Curritino Marting 21502

State Registrar

Medical Certification: To

32. Registrar's Signature

6-08015			Pleas	е Туре	or Prir	nt in B	lack Inde	elible	lnk						
Blenn Bernard [		,	tate of Maryla	and / De	epartme	ent of	Health ar			jiene					
		1- For State Registrar		(	Certifica	ate of	Death				Reg. No.	20	006	3486	5
Physici Medical Exami		Decedent's Name (First, Middle	_	D 1						Date of Dea Month October 2		Year		3. Time of Death 1105 hrs	
VICUICAI EXAIIII	He	Glenn Be	ernard on give street and ni		ahay	4	. City, Town, o	Location		October 2		County o	f Death	11051115	
		22810 Dorsey St. Apt		,			Leonardtov					t. Mary			
Funeral		5. Social Security Number	6 Sex	7. Age (In y	rs. last birtl	nday)	If Under 1 Year Months Day		$\overline{}$	8. Date of Bi	rth(MM/[	DD/YYYY)	9. Birth Foreign	nplace (State or	_
Director		218-90-0538	1 X M 2 F		43	Yrs	Months Day	s Hour		03/24	/196	3		ntry)Maryland	d
ž.		Usual Residence of Decedent  10a. State 10b County		10c	City, Town	or Locatio	<u> </u>							10d. Inside City Limit	· c
ow ar				100.	Oity, 10mil	or Educatio		1 4					- 1	1 Yes 2 N	
nylancia-f sh	향	Maryland St  10e. Street and Number	t. Mary's			Т	Leonar	LOWI	1		10a Citiz	en of Wh			_
215-0036 be filed within 72 hours after death with the Maryland ntal Hygiene. rked other than "natural", or items 23a or 28a-f show any ent, the Medical Examiner must be notified at once.	Director	22810 Dorsey	Street.	Apt. 2	12		21	0650				ited		•	
eath with t items 23a ust be not		11. Marital Status	12. Was De	cedent Ever		13. Was	Decedent of Hi	spanic On	igin? (Spec	ify Yes or No		14. Race	- Americ	an Indian, Black,	_
death or iter	Funeral		arried Armed F	2 X N	No		s, specify Cuba			can, etc.)		White	, etc.		
s after ral",	à		orced If Yes, Give Ye or Dates:				es 2X No					Specify <sup>-</sup>			
21215-0036 uld be filed within 72 hours after Mental Hygiene. marked other than "natural", c event, the Medical Examiner.	Completed	15 Decedent's Education (Specific Elementary/Secondary (0-12)		1-4 or 5+)	d) 16a. l		Usual Occupa t of working life				16b. K	ind of Bus	iness/In	dustry	
36 thin 72 than than edical	ng l	12	oonogo (	1 10.01		Сотт	outer D	rafti	ng		De	fenso	e Co	ntractor	
5-0( led will tygier other	S	17. Father's Name (First, Middle,	Last)			00111				irst, Middle,					_
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica	Be	Bernard Yates								nbar .					
D 21 should and Mer 7 is man	입	19a. Informant's Name/Relations		n . 1	119		Address (Stree								
Z G d d m	- 1	Bernard Y. De	elanay /				Box 451			own, l				own, State	_
IOFE		1 XBurial 2 Cremation	No.	rom State		ory or othe			10.00	2006			•		
Baltimore, permit Pages I ar Department of Hee Important: If ite	-	4 Donation 5 Other Sp. 21. S of Funeral Service		)	St. A		Lus Cem							, Maryland	1
Den perm		Edward N. Bri	1 -	Jr. M	00052										9
Physician	-	23a. Part I. Enter the disease, or failure. List only one cause	complications that of	caused the de	eath. Do no	t enter the	mode of dying	such as c	cardiac or re	espiratory arr	rest, shoo	ck, or hear	rt	Approximate Interval	3
/Medical Examiner		Immediate Cause (Final disease	4 - 1	cleroti	ic card	ioascu	dar dise	ase						Death	'
		or condition resulting in death)	Due to (or as a	a consequen	ce of):										
	ē	Sequentially list conditions, if any, leading to immediate	Due to (or as a	a consequen	ce of):										-
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38760, rifficate be ed ing physician as the burial	Mec	IF FEMALE:	23c If yes,	outcome of		enur.	G861, 11	30/06	) 11		23d	Date of c	delivery		_
Box 68760, e death certificate be ex the attending physician ed for use as the burial	Physician/Medic	23b. Was decedent pregnant in th past 12 months?	LIVE	birth nant at time o	of death _			Ectopi	c pregnancy	/	1	Month	Da	y Year	
30x death ne atte	ysic	1 Yes 2 No 9 Unk			or death 5	Othe	r (Specify)								
P.O. Be st that the digned by the detached		Part II. Other significant conditi	ions contributing t	o death but r	not resulting	in the und	derlying cause i	jiven in Pa	art I.	23e. Did to	obacco u	se contrib	ute to th	e cause of death?	_
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Recc The lay icate ha	Ē						-			perfo	rmed?	de	eath?  Yes	2 No	
al F	യി	25. Was case referred to medical examiner?					26 Place		(Check only	y one)					_
of Vital Recing Physician: The After this certificate uneral director, page	10 B	1 Yes 2 No		Inpatient 2		tpatient		Other <sub>4</sub>	Nursing H			nce 6 🗸		Scene	
Division of Vital Records, nater of the law requires after death.  al Director: After this certificate has been shed in by the funeral director, page 2 should the law has been the funeral director, page 2 should the law has been as been in by the funeral director, page 2 should the funeral director.	ü	27 Manner of Death 1 X Natural 5 Pend		of Injury n, Day,Year)	28b T	ime of Inju		ry at Work 'es 2	_	d Describe	how injur	y occurre	d		
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Hospi 24 hou Funer ely fil		29a Certifier	hysician: To the be		vledge, dea	th occurre	d at the time, da	ate and pla	ace, and due	e to the caus	se(s) and	manner a	s starte	d	-
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the burn	Medical	(	miner: On the basis and manner s	of examination	-										
F 3 F 8	Me	29b. Signature and title of certifie					29c. Licens	e number			29d D	ate signer	d (Monti	h, Day, Year)	
		Panik Tva	thall of	40			O.C.	M.E.			Octo	ber 26,	2006		
	Ì	30. Name and address of person		,	,		Danii Ci	D-111		04004	•				1
[	- 1	Pamela E. Southall, M	ID ASSISTANT	iviedical b	xamıner	111	Penn Stree	., Baitim	nore, MD	Z1ZU1					- /

ORIGINAL

State 31. Date filed (Month, Day, Year)
Registrar UC 1 2 7 2006

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Alan N. Donnell October 0 14, 2006 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Silver Spring If Under 1 Year | If Under 24 Hrs. Montgomery Holy Cross Hospital 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Hours 1**X** M 2□ F Aug 4, 042-30-2895 68 1938 Maine Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 NiNo Silver Spring Maryland Montgomery 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 20910 733 Sligo Ave, #607 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1♥]Yes 2□NKorean IfYes, Give Year or Dates:Conflict 1 ☐ Yes 21 No Specify: 3 ₩idowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Administration Law Enforcement 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Faustina Robertson Clayton Donnell 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 23 South Bruce St, Laurel, MD 20724 Alan J. Donnell/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Fort Linoln Crematory Oct 24, 2006 Brentwood, MD 21. Signature of Funeral Service Licensee 22. Name and Address of FacilityHines-Rinaldi Funeral Home 0-00 11800 New Hampshire Ave, Silver SPring, MD 20904 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Multiple Cerebral Infarctions Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Uniderlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of) 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Hypertension 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Xinknown 24b. Were autopsy findings available prior to completion of cause of 24a Was an autopsy performed? death? 1□ Yes 2 No

Physician /Medical Examiner Examiner

physician

Department of I Important: If Its any injury or o

Physician

/Medical

Examiner

Director

Funeral

Completed by

Be ပ

**Funeral** 

Director

or be

the Maryland r 28a-f show notified at

Pages 1 and 2 should be filed within 72 hours after death with t nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 2 ury or other traumatic event, the Medical Examiner must be n

altimore, Maryland 21215-0036

the attending p led by the atten detached for u page 2 ers after death,

eral Director: After this certific:
filled in by the funeral director, Be P

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Completed

Certification:

Medical

The law requires that the death certificate be executed

Hospital or Attending Physician:

To the

within 24 hours a

To the Funeral I

Division or Vital Records, P.O. Box 68760,

Physician/Medical

25. Was case referred to medical examiner? 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 1 ☐ Yes 1 Inpatient 2 TER/Outpatient 3 □ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27, Manner of Death 28b. Time of 28d. Describe how injury occurred Injury 1 ☑ Natural 2 ☐ Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

29a. Certifier (Check only one)

29b. Signature and title of certifier

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

D52261

29c. License number

29d. Date signed (Month, Day, Year)

October 15, 2006

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hugo Cir, Alan R. Segal, MD 1517 Silver Spring, MD 20906

State Registrar 31. Date filed (Month, Day, Year) 2006 OCT 19

			For State Registrar		State o	f Ma	ryland		irtment of F tificate of		Mental Hy	giene ()	06	34869
	sicia		1. Decedent's Name Elizabeth		*	-					2. Date of D Month Octobe	eath Day	Year 2006	3. Time of Death
	edic min		4a. Facility Name (If			mber)			4b. City, Town, o	r Location of De			nty of Deat	12:40 p M
			National L		Home				Rockvill			Mont	gomer	ТУ
Fune Direc			5. Social Security Nu 578–48–89	15	ex □M 2▼F	-	(In yrs. las:	t birthday) Yrs.	If Under 1 Year Months Days	If Under 24 H Hours Mi	n. (Month, D	rth ay, Year) y 30,19	Co	hplace <i>(State or Foreign</i> buntry) [assachusett:
and			Usual Residence of I	Decedent 10b. County			10c. City, T	Town or Loc	cation					10d. Inside City Limits
Maryl -f sho		ğ	Maryland	Montgome	ery		Rockv	ille						1 ☐ Yes 🏋 No
h the		Directo	10e. Street and Num						10f. Zip Code			10g. Citizen o	of What Co	ountry?
th wit	151		9701 Vier	s Drive					20850			United	Stat	es
15-0036 72 hours after death with the Maryland "natural", or Itams 23a or 28a-1 show		by Funeral	11. Marital Status 1 ☐ Never Marrie 3 ☒ Widowed 4		12. Was Dece Armed Fo 1 Tes If Yes, Giv Year or D	rces? 2 ∰ No ⁄e			Vas Decedent of H Yes, specify Cuba ☐ Yes 2 No	lispanic Origin? an, Mexican, Pue Specify:	(Specify Yes or Nerto Rican, etc.)		lace - Ame lack, White cify: Whi	
5-0036 72 hours af natural; or	101	ted		15. Decedent's E	ducation	4103.	1	I6a. Deced	ent's Usual Occup	ation		16b. Kind of	Business/	Industry
		Completed	(Specification)	y only highest gra dary (0-12)	completed) College (1	I-4or 5+		(GIVe I	kind of work done OO NOT use retired	durina most of w	rorking			,
Z begin		Co			4			Nurse				Hospi		
dala S		Be	17. Father's Name (F Harry Rab							18. Mother's N Flora E	ame (First, Middle	, Maiden Sum	ame)	
Marylar id 2 should be the and Menta 27 is marked		ဥ	19a. Informant's Nan	ne/Relationship /	Type, Print)			19b. Mailin	g Address (Street			er City or Tou	m State 7	Tin Code)
N _		П	John Daws		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,				Vorlick 1					.p (000 <del>0</del> )
O FEE	5		20a. Method of Dispo	sition		_	20b. Place	e of Dispos	sition (Name of atory or other place	-	Date Date	20c. Locatio		Town, State
Pages nent of ant: ff its			1 ☐ Burial 24∑ 1 ☐ Donation 5	Cremation 3 C		State			oln Cemet		18-2006	Brenty	wood,	MD
Department Pag Important: 1	once.		21. Signature of Funda	eral Service Liger	- L Way				Name and Addres		imple57r	ibute,	1040	Rockville
	<i>*</i>		23a. Part1. Enter the shock, or heart	disease, or com failure. List only	plications that cone cause on e	aused th	ne death. I	Do not ente	r the mode of dyin	g such as cardi	ac or respiratory a	rrest,		Approximate Interval Between
Physici			Immediate Cause (F disease or condition	ina)	a ( )	0	Lon	ar	5 and	lery,	dise	rele		Onset and Death
/Medic Examin			resulting in death)	(	Due fo	or as a	consequen	ice of):	/					Math
	tu-	e.	Sequentially list conditions if any, leading to imm	ditions, nediate	b. Due to	or as a	consequen	ice of):						MORITAS
utad d ansit		Examiner	Sequentially list condif any, leading to immicause. Enter Underly Cause (Disease or in that initiated events	ying ijury	•									
b8/bU, ficate be executed physician and sthe burial-transit			resulting in death) La	st	Due to (	or as a	consequen	ce of):						
<b>58/50</b> ficate be e physician is the buri		edical			d									··-·
Certifical Conding plants as a second		Med	IF FEMALE:		20- 11	,								
death death e atter		hysician/M	23b. Was decedent p in the past 12 m 1 ☐ Yes 2 ☑ 9 ☐ Unknown	enths?		irth 2 ant at tir	pregnancy Fetal de	ath 3 🗆 i	Ectopic pregnancy Other <i>(specify)</i>				Date of deliver of deliver of the de	very Day Year
BCOLDS, P.O. law requires that the as been signed by th 2 should be detachs			Part II. Other signific	ant conditions	ontributing to de	ath but	not resultin	ng in the un	derlyin j use give	en in Part I.	23e. Did t	obacco use co	ntribute to	the cause of death?
ord equire sen sign ould b			A.	rges	IM	lan	11	Ca	ellere		1 🗆	Yes 2 4No	3 ☐ Pro	bably 4 Unknown
The lar		Completed	44	ti at	K b	^. <i>/</i>	lat !	19-	-chri	m. C	24a. Was auto perfo 1  Yes	an 24b osy rmed? 2 2 No	prior to co death?	opsy findings available ompletion of cause of
VITAL ician: T certificat ector, pa		Be	25. Was case referre examiner?		Hospital:				0.5		Sath (Check only o	one)		
Phys r this	1	2	1 Yes 2 7. Manner Death	o	28a. Date of	npatient		Outpatient		4 Nursing	Home 5 Resident			ify)
Orn Iding th. : After		Lion	1 Natural 2 Accident	5 Pending investigation	(Mont	h, Day	/ear)	Injury	28c. Injury Work	rat ?? Yes 2∐No	20d. Describe	low injury occi	шед	
VISION Attanding Pr death. ractor: Afte		lica	3 Suicide	6 Could not be	28e. Place	of Injury	- At home	, farm, stre	et, factory, office		28f. Location (.	Street and Nun	nber or Rui	ral Route Number,
tal or s after s after bird bird bed in 1		Certification:	4  Homicide		Duildir	ng, etc.	(Specify)				City or To	vn, State)		
UNISION OF VITA  To the Hospital or Attanding Physician: within 24 hours after death. To the Funaral Diractor: After this certifical completely filled in by the funeral director.		edical	29a. Certifier 1 (Check only 2 one)	Certifying Ph	ysician: To the niner: On the ba and mann	asis of ea	xamination	dge, death and/or inve	occurred at the timestigation, in my op	e, date and place pinion, death occ	ce, and due to the curred at the time,	cause(s) and n date and place	nanner as :	stated. to the cause(s)
O With Co			29b. Signature alld tit	tle of certifier	W./	Ca	resi	ho	29c. License	217	26	29d. Date sign	ed (Month,	Day, Year)
1			30. Name and addres											
			Charles						oad; Dam	ascus, l	Maryland	20872		
	Stat istra	_	31. Date filed (Month,	1 8 200		eyisirar'	Signature	Goan	W					

			1 = For State Registrar	State of	Marylaı		artmen rtificat			and M	lental Hy	giene	0.0	6	34870
	Physic	ian	Decedent's Name (First, Middle, I	/							2. Date of De Month	eath Day		Year	3. Time of Death
	/Medi	cal	Charles Patrick								Octob			006	9:15 PM
Ž.	Exami	ner	4a. Facility Name (If not institution, g						Location of	of Death			County o		
الخب			Washington Count  5. Social Security Number 6.	J		to a tild to b	If Under	gers	COWN	0411			lashi		
ı	Funeral Director		219-12-2095 Usual Residence of Decedent	1₫M 2□F	79	. last birthday) Yrs.	Months		Hours	Min.	8. Date of Bir (Month, Da Dec. 1	7, 1	926	9. Birthp Coun Mar	place (State or Foreign htry) yland
	land ow		10a. State 10b. County		10c. C	ity, Town or Lo	cation							1	0d. Inside City Limits
	Mary	ğ	Maryland Wash	ington		Hanco	ock								1⊠Yes 2 No
	r 28a	Director	10e. Street and Number				10f. Zip	Code			T	10a. Citi	zen of Wh	nat Coun	atry?
	3a o	O E	301 Quality Cre	ek Apartm	ents				1750			_	SA		,
	ours after death with the Marylan ral', or iteme 23a or 28a-f ehow Examinar must be moutified at	Funeral	11. Marital Status	12. Was Decede	ent Ever in U	J.S. 13.	Was Dece			gin? (Spe	ecify Yes or No Rican, etc.)			- Americ	an Indian,
စ္	after or its		1 ☐ Never Married 2 🔀 Married	Armed Force 1 X Yes 2 If Yes, Give		1				, Puerto	Rican, etc.)		Black,	White,	
8	hours after death with the Maryland tural', or iteme 23a or 28a-f ehow al Esachinal must be rediffed at	ğ	3 ☐ Widowed 4 ☐ Divorced	Year or Date	s:WW I	I	1 🗆 Yes	2 <u>K</u> J No	Specify:				Specify:	W	hite
21215-0036	within 72 hours ene. then "naturel" the Medical Ex	Completed by	15. Decedent's (Specify only highest g		or 5+)	16a. Deced (Give life.	dent's Usua kind of wo DO NOT us	rk done d	urina most	of worki	ng	16b. Kir	nd of Bus	iness/Inc	dustry
2		Son	12	0		Produ	iction	n cor	ntrol:	ler			gove	rnme	nt
p	be filed htal Hygi ed other event, I	Be (	17. Father's Name (First, Middle, Las	•					18. Mothe	r's Name	(First, Middle	, Maiden .	Sumame,	)	
<u>ya</u>	should be and Mental marked o	2	Michael Landon D	onegan					Ma	ry B	lanche	Widm	yer		
, Maryland	s 1 and 2 should if Heelth and Mer item 27 is marks other treumatic		19a. Informant's Name/Relationship Margaret L. Done		e						, Hanco				
Baltimore,			20a. Method of Disposition 1 ♣ Burial 2 ☐ Cremation 3	□ Bomoval from Str		Place of Dispo cemetery, cren	sition (Nan	ne of ther place	p)	D	ate	20c. Loc	cation - C	ity or To	wn, State
Ē	permit. Pages Depertment of I Importent: If It eny Injury or o		4 Donation 5 Other (Spec			se Hill				10/2	8/06	Hag	erst	own,	Maryland
at	Depertiments import in Injury		21. Signature of Funeral Service Lice	ensee N	75	2	Name an	d Addres	s of Facility	M	INNICH	FUNE	RAL :	HOME	
<u> </u>	20 E 2 9	1.1	1 - 204	11/1/	um	my 41	5 E.	Wils	son B	lvd.	, Hager	stow	n, M	d. 2	1740
	Physician /Medical Examiner	ner	23a. Part1. Enter the disease, or conshock, or heart failure. List ont Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	a. Due to (or	as a consecutive of the consecut	quence of):	0	Ac	mid	out t					Approximate Interval Between Onset and Death
68760,	The law requires that the death certificate be executed site has been signed by the ettending physicien and bage 2 should be detached for use as the burial-transit	fedical Examiner	resulting in death) Last	cDue to (or	as a conseq	quence of);									
P.O. Box	es that the death certific igned by the ettending F be detached for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcor 1 Live birth 4 Pregnant 9 Unknown	2 Feta	Il death 3	Ectopic pre Other (spe					2:	3d. Date of Month		ry Day Year
ds, P	signed of be det	by	Part II. Other significant conditions	contributing to deat	n but not res	ulting in the un	nderlying ca	ause giver	n in Part I.			obacco us		ute to the	e cause of death?
Ö	w require been si should t	ete									-				
		Completed								_	24a. Was autop perio 1 🗆 Yes	rmed?	prio	re autop or to com ith? Yes 2	sy findings available ipletion of cause of
<del>=</del>	sicier certii recto	Be	25. Was case referred to medical examiner?	Hospital:				-			Check only o				
ō	Physical displays	Ľ.	1 ☐ Yes 2 🔯 No 27. Manner of Death	1/2Nnpa		ER/Outpatient 28b. Time of			4 🗀 Nur:		ne 5□Resid			(Specify)	)
0	After fune	5	1 SAlatural 5 ☐ Pending	28a. Date of li (Month, i	Day Year)	Injury	M	Work?			8d. Describe h	iow injury	occurred		
ivisi	l or Attending Physicien: after death. Director: After this certifica i in by the funeral director,	Certification:	2 Accident Investigation 3 Suicide 6 Could not 1 4 Homicide determined	28e. Place of	Injury - At ho	ome, larm, stre			es 2 🗆 N		8l Location (S City or Tow	Street and m, State)	Number	or Rural	Route Number,
	To the Hospital or within 24 hours after To the Funeral Dir completely filled in	Ce	29a. Certifier 1 Th Certifying P	hysician: To the be	st of my kno	wledge death	Occurred a	at the time	data and	Diago a	and relicate the				
	24 h 24 h Fur	edical	(Check only 2 Medical Exa	miner: On the basis and manner	or examina	tion and/or inv	estigation,	in my opi	nion, death	occurre	d at the time,	date and p	nd mann lace, and	er as sta I due to t	ited. the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier				29c.	License	number			29d. Date	signed (A	Month, D	lay, Year)
)	0			5				0	523	327		10-			
			30. Name and address of person who	completed cause of	f death (Item	n 23a) (Tvne F	Print)			, - ,		, -		(	S
HC	-3+1		Dr Wanes	1101	(1)	al Co	eint	1	tra	12	d 2	17	40		
	Sta	te	31. Date filed (Month, Day, Year)	32. Regi	strar's Signa		4		-	V.					
1	Registra	ar	00124	2006	*P-14 =	14 1	20.01	į.							

ORIGINAL

DHMH 17 Rev 1/2001

			1 - For State Registrar	State of	Marylan		artment of I		Mental Hyg	iene	06	34871
8	Physici	#	1. Decedent's Name (First, Middle, La	st)					2. Date of Deat Month	h	Year	3. Time of Death
	/Medic			auter					0ctober	23	2006	2;07 A M
	Examir	er	4a. Facility Name (If not institution, given	e street and numb	er)		4b. City, Town,	or Location of Dear	h	4c. Coun	ty of Death	
			1922 Abbey Lan 5. Social Security Number 6.5		A = 2 // 2	In a A b Lab day 1	M Llader 1 Vans	lagerstow	ın		Wash	nington
H	Funeral Director			1 ☐ M 2X F /	Age (In yrs. 54	Yrs.	If Under 1 Year Months Days		(Month, Day,	Year)	9. Birthpl	lace (State or Foreign try)
	-71.00		Usual Residence of Decedent		24				April 2	0,1952	Mar	yland
	yland		10a. State 10b. County		10c. Cit	y, Town or Lo	cation				10	0d. Inside City Limits
	e-1 e	to	Maryland Washin	aton		Had	gerstown					1 ☐ Yes 2 🛣 No
	or 28	by Funeral Director	10e. Street and Number				10f. Zip Code		1	0g. Citizen o	What Coun	try?
	23a	20	1922 Abbey Lan	e				21740			USA	
	ep u	ne	11. Marital Status	12. Was Decede Armed Force	es?	.S. 13. \	Vas Decedent of I	Hispanic Origin? (S san, Mexican, Puer	Specify Yes or No- to Rican, etc.)		ace - America	an Indian,
36	or i	y Fi	1 Never Married 2 Married	1 Tes 2	* *		□ Yes XX No		, ,	Spec		
0	ture	PG I	3 ☐ Widowed 4 ☑ Divorced  15. Decedent's E	Year or Date	os:	160 Doors	last's Haust Ossu				VV	/hite
<u>1</u>	within 72 hours after death with the Maryland ene. then "naturel", or iteme 23a or 28e-1 ehow he Madical Examitter fund be notified at	Completed	(Specify only highest gra	de completed)		(Give	lent's Usual Occup kind of work done DO NOT use retire	pation during most of wo id)	rking	16b. Kind of	Business/Ind	lustry
212	l with	E	Elementary/Secondary (0-12)	College (1-4	or 5+)		kkeeping				Bank	
D	othe	Bec	17. Father's Name (First, Middle, Last	)			tite op i ng		ne (First, Middle, M			
<u>lar</u>	vid by Menta rrked rice	To E	Isaac Howard	Forsythe	دِ			Jean	JoAnne	Byers		
Maryland 21215-0036	and I		19a. Informant's Name/Relationship (	Type, Print)		19b. Mailin	g Address (Street		ıral Route Number,		n, State, Zip	Code)
	and ealth m 27		Cody L. Delauter	- Son			Abbey La	ane Hage	rstown, M	lary la	nd 21	740
ore	Tof H If ite		20a. Method of Disposition  XX Burial 2 Cremation 3	Removal from Sta		lace of Dispo: emetery, cren	sition (Name of natory or other pla	ce)	Date 2	20c. Location	· City or Tov	wn, State
Ē	tmen tant:		4 ☐ Donation 5 ☐ Other (Spefit		Riv	/erviev	Cemeter	y Oct.	25,2006 W	lilliar	nsport	,Maryland
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If item 27 is marked other then "naturel", or iteme 23a or 28e-1 show eny fighty or other traumatic event, the Mudical Examination will be notified at once.		21. Sign fure of uneral in its included	S00				merelly Ho				21795
			23a. Part1. Enter the disease, or com	plications that saw	and the death	42	25 S. Cor	nococheag	ue St. Wi	lliams	sport,	
ı			shock, or heart failure. List only Immediate Cause (Final	one cause on each	h line.	i. Do not ente	ir the mode of dyl	ng, such as cardia	or respiratory arre	st,		Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a	160	ist	C 01	MOD			7	-O months
	Examiner		1	Due to (or	as a consequ	uence of);					,	
1	- T	er	Sequentially list conditions, if any, leading to immediate cause. Enter Unders in Cause (Disease or injury	b. Due to (or	as a consequ	uence of):						
	uted d ansit	Examiner	Cause (Disease or injury that initiated events	c.								
oʻ	be executed sician and burial-transit	Ex	resulting in death) Last		as a consequ	ience of):						
8760	3 > 6	dlcal		d								
9	leath certifica attending ph	/Mec	IF FEMALE:	03- 4						1		
Вох	attend for us	lan	23b. Was decedent pregnant in the past 12 months?		2 Fetal	death 3	Ectopic pregnancy	y			ate of deliver	y Day Year
o	y the	Physician/Med	1 □ Yes 2 No 9 □ Unknown	9 Unknown	tat time of de	atri 5	Other (specify) _			- Andrews		
<u>a</u>	res that the de igned by the a be detached t	by Ph	Part II. Other significant conditions of	ontributing to death	n but not resu	alting in the un	derlying cause giv	ren in Part I.	23e. Did tob	acco use con	tribute to the	a cause of death?
Vital Records,	requires that the leen signed by th hould be detache	d b							1 🗆 Yes	2 DNo	3 Proba	ibly 4 □Unknown
ဝ္		Completed							24a. Was an	24b.	Were autop	sy findings available
ž	sicien: The law certificete has b irector, page 2 sl	mo							autopsy perform 1 ☐ Yes 2		prior to com death?	pletion of cause of
ita	ien: rtifice	Bec	25. Was case referred to medical				**	26. Place of Dea	th Check on vone		1 ☐ Yes 2	2U N0
<u>&gt;</u>	Physic this ce al dire	10	examiner? 1 🗆 Yes 2 No	Hospital: 1   Inpa	atient 2 🗆 E	ER/Outpatient	3□ DOA Oth	er: 4 Nursing H	ome 5 Resider	nce 6 Ott	ner (Specify)	
ב	ding Ph h. After th funeral		27. Manner of Death  Natural 5 ☐ Pending	28a. Date of Ir (Month, I	njury Day Year)	28b. Time of Injury	28c. Injur Wor	y at k?	28d. Describe how	v injury occur	rred	
<u>s</u>	uttendi death. ctor: A y the fu	cat	2 Accident investigation 3 Suicide 6 Could not be					Yes 2 No				
Division of	after death after death Director:	Certification:	4 Homicide determined	286. Place of	Injury - At hor etc. (Specify	me, farm, stre	et, factory, office		28f. Location (Stre City or Town,	et and Numi State)	ber or Rural	Route Number,
	pite ours erel		29a. Certifier Certifying Ph	ysician: To the be	st of my knov	viedge, death	occurred at the tir	ne, date and place	, and due to the cau	ise(s) and m	annor ac cla	tod
	ne Hos ne Fun sietely	edical	(Check only 2 Medical Exan	niner: On the basis and manner	or examinati	ion and/or inv	estigation, in my o	pinion, death occu	rred at the time, dat	te and place,	and due to t	the cause(s)
	To the within 2 To the complet	M	29b. Signature and title of certifier		A		29c. Licens	e number	29	d. Date signe	ed (Month, D	ay, Year)
}			Multer	1 1 1 x	عالم	MIN	1) D	4647	3	10/3	14/8	06
	5 W 1		30. Name and address of person who	completed cause o	f death (Item	23а) (Туре, Р	rint)	, , , , , , , , , , , , , , , , , , , ,	. 11		. 1	
10	11-4		Hind Ham	dan,	MI)	, 113	OOP	ALCI	·Hade	eriste	wn, M	1) 2/140
	Star Registra	_	31. Date filed (Month, Day, Year)  OCT 2 4 2		strar's Signat	4 1	121		1			
7 6 7	- C   200 (4)			A STOCK OF	war to	101						

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
AMEND, TTEM#19a, perFH, C861, 11/2/06, WS
State of Maryland / Department of Health and Mental Hygiene

		1	For State Registrar	State of Ma	aryland 7 Dep <i>Ce</i>	artment of He rtificate of D		ntal Hygie Reg.	ZIIIIb	34872
			Decedent's Name (First, Middle, La				2.	Date of Death Month	Day_ Year	3. Time of Death
П	Physicia /Medic	_	JOYCE	KE	WERS			10	24 06	
	Examin	_	4a. Facility Name (If not institution, give	re street and number)		4b. City, Town, or L	ocation of Death		4c. County of Deat	
			C.J. Senior Ca	re Home	e (In yrs. last birthday,	Hagersto		Date of Birth	Washingt	
	Funeral Director		0. 000	1 □ M 2 1 F	7.5 Yrs.	Months Days	Hours Min.	or. 2, 1	931 WV	hplace (State or Foreign untry)
			Usual Residence of Decedent							
	nyland how		10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside City Limits 1 ★Yes 2 No
	8a-f	cto	MD Washi	ngton	Hagerst			10-	Citizen of What Co	
	with the	Dir	10e. Street and Number			10f. Zip Code		log.		unu y :
	eath is 23	eral	10127 St. Georg	e Circle 12. Was Decedent	Ever in U.S. 13.	21740 Was Decedent of His	panic Origin? (Specif	y Yes or No-	USA 14. Race - Ame	
36	s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23s or 28s-f show other traumatic event. It is Noolcal Exumator must be mailfied at	by Funeral Director	1 Never Married 2 Married 3 XWidowed 4 Divorced	Armed Forces? 1 ☐ Yes 2  If Yes, Give Year or Dates:		If Yes, specify Cuban  1 ☐ Yes 2\( \text{YN} \)	, Mexican, Puerto Ric Specify:	an, etc.)	Specify: Wh	e, etc. ite
21215-0036	2 hou	Completed by	15. Decedent's E			edent's Usual Occupat skind of work done du		168	b. Kind of Business/	Industry
215	within 7. ene. than "n	ηpie	(Specify only highest gr Elementary/Secondary (0-12)	College (1-4or !	life.	DO NOT use retired)	ining most or working			
	e filed within al Hygiene. I other than '	ទូ	12		Soc	ial Worker	<b>r</b> 18. Mother's Nam <i>e (F</i>	irot Atiddle Atei	Human Se	rvices
Ind	be fill htal Hi d oth	Be	17. Father's Name (First, Middle, Las	1)		ALLEA OF THE PROPERTY OF THE P			den Sumame)	
Maryland	should be ind Mental marked ( umatic ev	ပ္	Roy Keister  19a. Informant's Name/Relationship	(Type Print)	19h Mail	ing Address (Street ar	Kathleen		ity or Town, State, 2	Zip Code)
Mai	d 2 st th and 17 is r		Jovce A Brown	- (daughter		27 St. Ge				
	ss 1 and of Health item 27 other to	01:	20a. Method of Disposition	(dadgireer	20b. Place of Disp		Dat	-	c. Location - City or	
<u>E</u>			1 ☐ Burial 2 ☐ Cremation 3 [ 1 ☐ Donation 5 ☐ Other (Special Control of Cont			Li F.H. PA		'06 C:	resapto <b>w</b> n	, MD
Baltimore,	permit. Page Department of Important: If any Injury or once.		21. Signature of Funeral Service Lice	1. 200	) 2	2. Name and Address	of Facility  Ch. Lane. Ro	ee Fune:	ral Home	Hamp LLC
			23a. Part1. Enter the disease, or conshock, br heart failure. List only	inplications hat cause	the death. Do not er	nter the mode of dying	, such as cardiac or r	espiratory arrest,		Approximate Interval Between
	Pnysician		Immediate Cause (Final disease or condition	CURN	NIC KU	NEY DY	CEASE.	STAG	E5	Onset and Death
	/Medical		resulting in death)		a consequence of):	1140	00,.00			-
١.	Examiner		Sequentially list conditions,	b						
_	D #	iner	many, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence of					
D.	and I-trans	Examiner	that initiated events resulting in death) Last	c. Due to (or as	a consequence of):					
58760;	icate be executed physicien and s the burial-transit			. d	,					
687	ficate g phys	edicai		0.						
O. Box	The law requires that the death certific the has been signed by the attending F page 2 should be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetel death 3	□Ectopic pregnancy □ Other (specify)			23d. Date of de Month	livery Day Year
P.O.	that the		Part II. Other significant conditions	contributing to death t	out not resulting in the	underlying cause give	n in Part I.	23e. Did tobac	cco use contribute to	the cause of death?
sp.	uires l signé	d by	PELVIC L	EIOMYO.	SARCO	MA		1 🗆 Yes	2 □ No 3 □ Pr	robably 4 Unknown
of Vital Records,	w require been signature should b	Completed						24a. Was an	24b. Were at	utopsy findings available
Re	The lar te has age 2	mo						autopsy performe 1 ☐ Yes 2	d? death?	completion of cause of 2 2 No
ta		a)	25. Was case referred to medical				26. Place of Death (			
_f <	> 20 0	To B	examiner? 1 ☐ Yes 2 No	Hospital: 1 Inpati	ent 2 ER/Outpatie		4 A Nursing Home		e 6 □Other (Spe	city)
n 0	ding Ph h. After th funeral		27. Manner of Death 1 X Natural 5 □ Pending	28a. Date of Inj. (Month, Da		Work		d. Describe how	injury occurred	
sio	a a a	cati	2 ☐ Accident investigati 3 ☐ Suicide 6 ☐ Could not	be on Blace of In	jury - At home, farm, s		'es 2 □ No	f Location (Stree	et and Number or R	ural Route Number
Division	l or Attend after death Director:	Certification;	4 Homicide determine	d 200. Flace of III	tc. (Specify)	illest, lactory, onice		City or Town, S		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
_	Hospita 4 hours Funeral	edical Co	29a. Certifier 1 Tertifying F (Check only one) 2 Medical Ext	Physician: To the best aminer: On the basis and glanner s	of examination and/or i	ath occurred at the tim nvestigation, in my op	e, date and place, an inion, death occurred	d due to the caus at the time, date	se(s) and manner as a and place, and due	s stated. a to the cause(s)
	To the within 2 To the complet	Med	29b. Signature and title of gertilier			29c. License	number	29d	. Date signed (Mont	th, Day, Year)
	F ≯ F ŏ		· MU	W		000	061411	1	0/25/0	6
	<b>)</b> .		30. Name and address of person wh			a, Print)			HAG	ERSTOWN 21742
	r			NAMOORTHY	MD MI		L CAMPUS RI	STEIS	D, MD	21742
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) 2	006 32 Regist	rar's Signature	reall?				

			1 - For State Registrar	State of Maryla		artment of I rtificate of			iene g. N. 0	6	34873
*	Physic /Medi	cal	Decedent's Name (First, Middle, Last)  LISA  4a. Facility Name (If not institution, give s	C. EL	DER	4. 0. 7.			1, 200		3. Time of Death 3:15 Am
	Exami	ner	20400 Alderlea: 5. Social Security Number 6. Sex	f Terrace	s. last birthday,		antown	rs. 8. Date of Birth	4c. County Mont	gom	
	Director		Usual Residence of Decedent	<sup>1M 2</sup> <b>2 2 3 4</b> 0	Yrs.	Months Days	Hours Mi	n. (Month, Day, May 1,			place (State or Foreign ntry)
	should be filed within 72 hours after death with the Maryland of Mental Hygiene.  marked other then "netural", or items 23a or 28a-f show imatic event, it a Madical Examinar must be netlified at	Funeral Director		eaf Terrace 12. Was Decedent Ever in Ammed Forces?	Э	rmantow 10f. Zip Code 2087	4	(Specify Yes or No-		What Coun	can Indian,
215-0036	n 72 hours af "netural", or agleal Exemi	Completed by F	1 Married 2 Married 3 Widowed 4 Divorced  15. Decedent's Educ (Specify only highest grade	1 ☐ Yes 2 ☑ ★o If Yes, Give Year or Dates: cation completed)	16a, Dece	1 Yes No	nation	rorking	Specify.	B1	ack dustry
	e filed Il Hygi other	Be Comp	Elementary/Secondary (0-12)  17. Father's Name (First, Middle, Last)	College (1-4or 5+)	Info	rmation	Tech.		Hughes		twork
Maryland 21	2 should to and Ment Is marked	2	19a. Informant's Name/Relationship (Typ	•				Rural Route Number,		State, Zip	
	Pages 1 and nent of Health int: If item 27 ary or other to		Walter Elder- F  20a. Method of Disposition  **X*Burial 2   Cremation 3   Re	20b.	Place of Dispo cemetery, crea	sition (Name of matory or other place	ce)		0c. Location -	City or To	wn, State
Baltimore,	permit. Pages 1 and 2 should by Department of Health and Menia Important: If item 27 is marked any Injury or other traumatic and one.		4 Donation 5 Other (Specify) 2) Signature of Funeral Service Lic. ns.	The state of the s	22	uls Cem R. Name and Addre 46 N. Wa	ss of Facility	/17/06 ( Snowden l ton St Ro	unera	1 Ho	ome, PA
Ì	Physician /Medical		23a. Part1. Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	cations that caused the dece e cause on each line.  ACUTE MY  Due to (or as a conse	ath. Do not end	er the mode of dyir	ig, such as cardi				Approximate Interval Between Onset and Death Year
876U,	rate be executed  xax  hysicien and  ine burial-transit	Ilcal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conse							6223
O. BOX 6	the death certificate y the ettending phys iched for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ Mao 9 ☐ Unknown	3c. If yes, outcome of pregr 1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of 9 ☐ Unknown	al death 3	Ectopic pregnancy	,		23d. Date Mon		ry Day Year
cords, P	w requires that the de been signed by the e should be detached f	þ	Part II. Other significant conditions cont	tributing to death but not re	sulting in the u	nderlying cause giv	en in Part I.				e cause of death?
Jec L	The law ete has b page 2 sl	Completed						24a. Was an autopsy perform	ed? de	ere autoprior to come eath?	osy findings available inpletion of cause of
VII	ysician: is certific director,	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ◯XNo	ospital: 1 ☐ Inpatient 2 ☐	7500	· all Doa Oth		eath Check only one		-	
VISION O	ath. or: After this oe funeral dir	atlon: To	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injun Worl	4 Li Nursing	Home 5 Residen 28d. Describe how			)
200	To the Hospital or Attending Physician: within 24 hours elfer death To the Funeral Director: After this certific completely filled in by the funeral director,	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At I building, etc. (Spec	ify)			28f. Location (Stre City or Town,	State)		
	the Hosp thin 24 ho the Fune mpletely fi	Medical	one)	ician: To the best of my kn er: On the basis of examin and manner stated.	owledge, death ation and/or inv	estigation, in my of	oinion, death occ	urred at the time, dat	e and place, ar	nd due to	the cause(s)
	F 3 F 8	_	29b. Signature and title of certifier	10 0		29c. License		296	d. Date signed		
1	7		30. Name and address of per whom Dr. C. Rajagor	npleted cause of death (ite	m 23a) (Type, Princ	Print)		#327 Oln			16, 2006
	Sta Registr		31. Date filed (Month, Day, Year)	32. Has been's Sign	ature A	certi			-1, 111	200	J J L

DHMH 17 Rev 1/2001

06-07936 Ronald Eisentrout Please Type or Print in Black Indelible Ink
WS
State of Maryland / Department of Health and Mental Hygiene

			1- For State Registrar	Certificate o	f Death			eg No 20	05 21.87
	Physicia I Exami		1. Decedent's Name (First, Middle, Last)  Ronald L. Eisentrout				2. Date of Deat Month October 22		1440 hrs
			4a. Facility Name (if not institution, give street and number)			or Location of Death		4c. County of	Death
	uneral		In woods: above Wigres Avenue  5. Social Security Number 6 Sex 7, Age (	(In yrs last birthday)	LaVale	ear If Under 24Hrs	s. 8. Date of Birt	Allegany	Birthplace (State or Foreign
	irector		220-34-2131 <sub>1</sub> * <sub>M 2</sub> <sub>F</sub> 6	58 <sub>Yr</sub>	Months D	ays Hours Mir		8 1938	Maryland
	any			Oc. City, Town or Loca	tion			-	10d. Inside City Limits
3	f show	jo.		LaVale					1 X Yes 2 No
	off the Maryland \$23a or 28a-f show any notified at once.	Director	10e. Street and Number 92 LaVale Blvd		10f. Zip Code 21502		10	Og Citizen of Wha	at Country?
3	Pages 1 and 2 should be lifed within 72 hours after death with the Maryland net of Health and Mental Hygiene.  Int. If item 27 is marked other than "natural", or items 23a or 28a-f she is other traumatic event, the Medical Examiner must be notified at once.	Funeral		If ` ■ No	Yes, specify Cub	Hispanic Origin? ( S pan, Mexican, Puerto		White,	
é	urs after tural".	þ	Widowed 4x Divorced If Yes, Give Year or Dates.  15. Decedent's Education (Specify only highest grade complete.	leted) 16a. Decede		pation (Give kind of		Specify: 16b. Kind of Bus	
36	permit Pages I and 2 should be tiled within 7.2 hours after death with programmer of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items injury or other traumatic event, the Medical Examiner must be	Completed	Elementary/Secondary (0-12) College (1-4 or 5+	+)	nost of working I	ife. DO NOT use ret	tired)	Electric	cal
15-0	Hygier Hygier d other		17 Father's Name (First, Middle, Last)					/ Name ( )	-> -:
212	Mental Mental marke	o Be	James Garfield Eisentrout  19a Informant's Name/Relationship (Type, Print)	19b. Mailir	ng Address (St	reet and Number or			r) Eisentrout State, Zip Code)
Q :	d 2 sho Ith and n 27 is urmati	-	Erik C. Eisentrout So			Dr., Lava		21502	·
Baltimore, MD 21215-0036	ages I an nt of Hea nt: If iter other tr:		20a Method of Disposition  1 XBurial 2 Cremation 3 Removal from State	20b, Place of Dispo crematory or o	ther place)	netery Oc	Date 27 06		city or Town, State
	permit P Departme Importar injury or		4 Donation 5 Other Specify  21 Signature of Funeral Service Licensee	22.	Name and Addre	-1	afer Fur	neral Ser	vice, PA
Ph	ysician Medical		20a Part I. Enter the disease, or complications that caused the failure. List only one cause on each line.			_			t Approximate Interval Between Onset and
	aminer		Immediate Cause (Final disease or condition resulting in death)  a Acute Coronary A		pture				Death
		L	Sequentially list conditions, b. Hypertensive Ath	erosclerotic Card	liovascular [	Disease			
		Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated						
	uted nd ransit		events resulting in death) Last Due to (or as a conseq d.	uence of):					
Ć.	icate be executed physician and the burial - transit	Medical	UNPENDED AMENDED						
68760,	certificate be ending physicials as the buria	_ =	IF FEMALE. 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome 1 Live birth		etal death	3 Ectopic pregn	ancy	23d Date of d Month	elivery Day Year
Box 6	death cer he attend d for use	Physiciar	1 Yes 2 No 9 Unknown Pregnant at tir	me of death 5 0	other (Specify)				
P.O.	hysician: The law requires that the death certifi this certificate has been signed by the attending I director, page 2 should be detached for use as	by	Part II. Other significant conditions contributing to death to	out not resulting in the	underlying caus	e given in Part I	23e. Did to		ute to the cause of death?  Probably 4  Unknown
Division of Vital Records,	aw requir as been s 2 should	Completed					24a. Was autop	sy pri	ere autopsy findings available for to completion of cause of eath?
Rec	The L ficate h	Com			26 Die	ace of Death (Check	1 🗸 Yes		Yes 2 No
/ital	vsician nis cert directo	o Be	25 Was case referred to medical examiner?  1 ✓ Yes 2 No Hospital: 1 Inpatient	t 2 ER/Outpatien		Othor		Residence 6	Other: Scene
of	ing P After funera	-	27. Manner of Death 28a. Date of Injury (Month, Day, Yea	y 28b. Time of		njury at Work?	28d. Describe h	now injury occurred	d
isior	Attend or death rector: by the	icatic	2 Accident Investigation 28e. Place of Inju	iry - At home, farm, stre		Yes 2 No	28f Location (S	Street and Number	or Rural Route Number, City
ρί	Hospital or 24 hours afte Funeral Dir tely filled in	Certification	3 Suicide 6 Could not be determined (Specify)		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		or Town, S		
	To the Hospital or Attend within 24 hours after death  To the Funeral Director: completely filled in by the:	Medical C	29a. Certifier 1 Certifying Physician: To the best of my lone) 2 Medical Examiner: On the basis of exami						
	To To	Me	and manner stated  29b Signature and title of certifier			ense number			(Month, Day Year)
			Carol Hallo	lin	0.0	C.M.E.		October 23,	2006
1	,		30. Name and address of person who completed cause of dea Carol Allan, MD Assistant Medical Exam		Street, Balti	more, MD 2120	01		
V	, S	tate	31 Date filed (Moulf) Day Year 2006 32 Registrar's	s Signature	34/23				

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		1 - For State Registrar	ND#16a/bp	State of M erFH10/18/06,1	ary≀ar ∃MW <b>,</b> Mc	id / Depa ∞ <i>Cer</i>	irtment of t tificate of	Health and <i>Death</i>	Mental Hy	ygiene Reg. No	2006	34875
Physici	an	Decedent's Nam     M	e (First, Middle, I ildred	ast) FEUERSTE	TN				2. Date of D	eath		3. Time of Death 5:27 P M
/Medic Examin		4a. Facility Name (	If not institution, g	rive street and number)				or Location of Dea		4c	. County of Dea	th
Funeral		Suburban  5. Social Security N			e (În yrs.	last birthday)	Beth If Under 1 Year	lesda If Under 24 Hr	s. 8. Date of B	irth	ontgomer	thplace (State or Foreign
Director		115-12-9 Usual Residence of			92	Yrs.	Months Days	Hours Mir	Oct. 1	3, Year	914 9	New York
aryland show	_	10a. State	10b. County			ty, Town or Lo						10d. Inside City Limits
the Marrage 1	recto	MD 10e. Street and Nu	Montgom	ery	Sil	Lver Sp	ring			10a, Cit	tizen of What Co	1 ☐ Yes 2 🛣 No
ath with	Funeral Director	11423 Co.	lumbia P				20904				USA	
filed within 72 hours after death with the Maryland Hygiene. Hygiene Hygiene Hygiene with then *nature!*, or Items 23a or 28e-( show ont, in a Medical Examinar must be notified at	by	11. Marital Status 1 □ Never Marr 3 및 Widowed	ied 2 Married	12. Was Decedent Armed Forces?  1  Yes 2  If Yes, Give Year or Dates:		If	Vas Decedent of N Yes, specify Cub ☐ Yes 2 No	Hispanic Origin? ( an, Mexican, Pue Specify:	Specify Yes or N rto Rican, etc.)	0-	14. Race - Ame Black, Whit	
netur	eted	(Spec	15. Decedent's cify only highest of	Education rrade completed)			ent's Usual Occup kind of work done		orking		ind of Business	
giene.	Completed	Elementary/Seco	ondary (0-12)	College (1-4or	5+)	Socr	orary SE	CRETAR	Y	U.5	GOVE	RNMENT
perfilt. Pages 1 and 2 should be filed within 72 hc peprfilt. Pages 1 and 2 should be filed within 72 hc Department of Health and Mental Hygiene. In Inspectant: If Item 27 is marked other then "naturenty injury or other treumatic event, Item Medical once."	To Be (	17. Father's Name Louis	(First, Middle, Late Gobioff	•				Bes	me (First, Middle sie Brav	verma	n	
and 2 sh ealth and m 27 is m	į	Moshe Gol	pioff, N		-	28 Bla	uvelt Ro	and Number or Foad, Mon	sey, NY	109		Zip Code)
Pages 1 nent of H ant: If Ite			•	☐Removal from State		emetery, crem	sition (Name of latory or other pla non Ceme	tery Oct	. 17, 20		ocation - City or Adelphi	
Depertrument in portrument in propertrument	21. Signature of Fu		10500	5			ess of Facility T				neral Home C 20012	
Pnysician /Medical	6 1	23a. Part1. Enter the shock, or heal Immediate Cause disease or condition resulting in death)	rt failure. List on (Final	mplications that caused by one cause on each li a	ne. کالاً	h. Do not ente						Approximate Interval Between Onset and Death
Examiner			nditions.	0.	STI	NAL	PERF	DRATIO	$\sim$			Hours
e executed ien and urial-transit	Examiner	if any, leading to im cause. Enter Under Cause (Disease or that initiated events resulting in death) I	orlying injury	Due to (or as								
م ف ف				Due to (or as	a conseq	uence or):						
Physicien: The law requires thet the death certificate this certificate has been signed by the attending physical director, page 2 should be detached for use as the	Physician/Medical	IF FEMALE: 23b. Was decedent in the past 12 1 ☐ Yes 2 ☑ 9 ☐ Unknown	months?	23c. If yes, outcome 1□Live birth 4□Pregnant at 9□ Unknown	2 □Feta	Ideath 3 □	Ectopic pregnancy Other (specify)	′			23d. Date of deli Month	very Day Year
w requires thet been signed b should be dete	ρ	Part II. Other signif	ficant conditions	contributing to death b	ut not res	ulting in the un	derlying cause giv	en in Part I.	1			the cause of death?
The law r cate has be page 2 sh	Completed								24a. Was auto perfo 1 ☐ Yes		24b. Were au prior to death?	topsy findings available completion of cause of
Physicien: Th r this certificate ral director, pag	o Be	25. Was case reference examiner? 1 Tyes 2		Hospital:	n 2/2	ER/Outpatient	3□ DOA Oth		ath (Check only	- /		
Jing After fune	H-4	27. Manner of Death	h 5 □ Pønding	28a. Date of Inju (Month, Da		28b. Time of Injury	28c. Injur Wor	y at	dome 5 ☐ Res 28d. Describe			city)
To the Hospital or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the funerel.	Certification;	2 Accident 3 Suicide 4 Homicide	investigati 6 ☐ Could not determine	be One Blace of Ini	ury - At ho c. (Specif)	ome, farm, stre		103 2 100	28f. Location ( City or To	Street and wn. State,	d Number or Ru )	ral Route Number,
To the Hospital or within 24 hours after To the Funeral Dir completely filled in in	edicai C	29a. Certifier (Check only one)	1 Certifying F	Physician: To the best of the basis of the basis of and manner sta	examina	wledge, death tion and/or inve	occurred at the tirestigation, in my o	ne, date and place pinion, death occi	s, and due to the urred at the time,	cause(s) date and	and manner as place, and due	stated. to the cause(s)
Within Company	Ň	29b. Signature and	title of certifier	S M			29c. Licens	e number 31027		29d. Date	e signed (Month	2006
			BRIGHT	completed wase of d	eath (Item	23a) (Type, P	rint)	D BET		m	20814	4
Star Registra		31. Date filed (Mont	th, Day, Year)	2006 Registra	ar's Signa	ture April		,				

Physici /Medio Examir

**Funeral** Director

	•	For State Registrar		State of Ma	ai yiai k	Се	artment of H	Death	vientai m	Reg. No.		34876
ician		Decedent's Name (First, Mic	idie, La	•					2. Date of D Month	eath Day		3. Time of Death
dica			kir		ust				Oct.	15,	2006	6:30 A M
ninei		4a. Fecility Name (If not institut						Location of Death	1		County of Dea	
		10401 Grosvenc 5. Social Security Number				ast birthday	Rockvi	.11e If Under 24 Hrs.	8. Date of B		ntgomen	
al or		578-62-9018		1□ M 2⊠ F	91	Yrs.	Months Days	Hours Min.	July 1	2,19	L5 N	rthplace (State or Foreign country) ew York
		Usual Residence of Decedent  10a, State 10b, Cour	nty		10c. City	, Town or L	ocation					10d. Inside City Limits 1 1 Yes 2 □ No
Filmeral Director	3	Md. Mon	tgoı	mery	R	ockvi.	11e			1		
i		10e. Street and Number		77	C 0 7		10f. Zip Code			10g. Cit	izen of What C	ountry?
i a	8	10401 Grosve	nor		627		208				USA	
2	3	11. Marital Status		12. Was Decedent I Armed Forces?		S. 13.	Was Decedent of H If Yes, specify Cuba	spanic Origin? (S) n, Mexican, Puend	pecify Yes or N o Rican, etc.)	10-	14. Race - Am Black, Wh	
2	2	1 Never Married 2 M 3 Widowed 4 Divorc		1 Tyes 2 25 N If Yes, Give Year or Dates:	NO		1 ☐ Yes 2 ☒ No	Specify:			Specify: W	hite
Completed	הפום	15. Deced (Specify only high Elementary/Secondary (0-12	hest gr	ducation ade completed) College (1-4or 5	(4.)	(Giv	edent's Usual Occup e kind of work done o DO NOT use retired	furing most of work	king	16b. K	ind of Business	s/Industry
Ę	5	Elomoniary/Socoridary (o 12		1		Home	Maker			<u></u>	Own H	ome
a d	200	17. Father's Name (First, Middle	e, Last	7)				18. Mother's Nam			Sumame)	
F		George Lewis	Sk	irm				Margare	t Dowli	ng		
1		19a. Informant's Name/Relatio	nship (	(Type, Print)		19b. Mail	ing Address (Street	and Number or Ru	ral Route Num	ber, City o	r Town, State,	Zip Code)
		Mary Bee Cimi	ne1	li/Daughte:			16 Hob Na	il Court				
		20a. Method of Disposition 1 ABurial 2 ☐ Crematio	n 2 [	Demoval from State	20b. Pf	ace of Disp metery, cre	osition (Name of Imatory or other place	θ)	Date	20c. Lo	ocation - City o	r Town, State
		4 Donation 5 Other			St.	Gabri	els Cem.	Oct.	.19,06	Poto	mac, Ma	aryland
once.		21. Signature of Funeral Service	e Lite	nspe ///			2. Name and Addres					
ä		Kurn	#_	SIM			222 Wiscon				., D.C	. 20007
		23a. Part1. Enter the disease, shock, or heart failure. L	or com	plications that caused one cause on each lir	the death	. Do not er	nter the mode of dyin	g, such as cardiac	or respiratory	arrest,		Approximate Interval Between
an		Immediate Cause (Final disease or condition		a Congest:	ive H	eart	Failure					Onset and Death Years
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u iii	ì	robuting in dodain, addi		Due to (or as	a consequ	ence or):						
1 2	3			d		_						
Ž		IF FEMALE:		23c. If yes, outcome	of progner							
Completed by Physician/M		23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ②No		1☐Live birth 4☐Pregnant at	2 ☐ Fetal	death 3	☐Ectopic pregnancy ☐ Other (specify)				23d. Date of de Month	Day Year
a v	2	9 Unknown		9□ Unknown								
2		Part II. Other significant cond			ut not resu	Iting in the	underlying cause give	en in Part I.	23e. Did	tobacco u	ise contribute (	to the cause of death?
7	2	Aortic Sten	osi	S					1	Yes 2	DN0 3□P	robably 4 Unknown
t d									24a. Wa		24b. Were a	utopsy findings available completion of cause of
Ē		-							per	opsy formed? 2 🔯 No	death?	s 2 No
a B		25. Was case referred to medi	cal				<del></del>	26. Place of Dea			10.10	3 2 140
L C		examiner? 1 ☐ Yes 2 ☑ No		Hospital:	nt 2 🗆 E	ER/Outpatie	nt 3 DOA Oth				6 □Other (Spe	ecify)
		27. Manner of Death	201	28a. Date of Injur (Month, Day	ry Vear)	28b. Time (	of 28c. Injun		28d. Describe			
i t		1 X Natural 5 ☐ Pen- 2 ☐ Accident inve	ding stigatio		, 102.7	IIII		Yes 2 □No				
Certification.		3 ☐ Suicide 6 ☐ Cou 4 ☐ Homicide dete	ld not b				reet, factory, office		28f. Location	(Street an	d Number or F	Rural Route Number,
a L	5	4 Tomodo		building, bu	o. (Openiy)	,			0.17 0.7 1	J, O.G.O	,	
Medical	alical			hysicien: To the best of miner: On the basis of and manner sta	examinati							
Z		29b. Signature and title of certi	fier		1		29c. License	number		29d. Dat	e signed (Mon	th, Day, Year)
		1071	)a	ven po	Vt			MD 41507		0ct	ober 1	6,2006
	1	30. Name and address of person						# -	00			2.6
		Nancy J. Dave					cico Ave.,	N.W. #2	02 Wash	1., D	.C. 200	16
State		31. Date filed (Month, Day, Ye		32. Registra	ars Signat	ure	No.					
istrar		OCT 18	20	Ub Reporter	. B.	16,500						

Registrar

10

			For State Registrar	St	ate of	Marylan		artmeni rtificate					giene Reg. N <del>o.</del>	006	348	17
			1. Decedent's Name (First, Middle	, Last)							2	2. Date of Dea	ath Day	Ye	3. Time of D	eath
	Physici /Medio		James Tow	nley	G	oldsm	ith				•	ctobe		,200		P
	Examin		4a. Fecility Name (If not institution	•		ber)		4b. City,	Town, or	Location of	of Death		4c. (	County of E	Death	
			Genesis Elde	r Ca	re					lata					rles	
	Funeral		5. Social Security Number	6. Sex 1√□ M		'. Age (In yrs.		If Under Months	1 Year Days	If Under Hours	Min.	. Date of Birt (Month, Da)	y, Year)	9.	Birthplace (State or I Country)	
-31	Director	**************************************	219-74-3205	X		50	Yrs.	** 939. They	امدان برالشواد المدان	Can bed	1	11y 5	, 195	6	Marylan	rq
and .	3		Usuel Residence of Decedent 10a. State 10b. County			10c. Cit	y, Town or Lo	cation							10d. Inside City	Limits
Z		5	MD Cha	rles			Newbu	Paper periodicity	The state of the s	AND DESCRIPTION OF THE PERSON	神神和此神			and a great of the same	1 ☐ Yes 2	No No
the	28a	ect	10e, Street and Number	1103	_		Newbu	10f. Zip	Code				10g. Citiz	en of Wha	t Country?	
with the	Pa or	٥	12860 Mt. V	icto	ria	Road			2066	54				USA		
eath	18 22 10 18 22	Funeral Director	11. Marital Status	12. V	Vas Deced	tent Ever in U	.S. 13.				gin? (Spec	ify Yes or No- can, etc.)		4. Race - /	American Indian,	
fter	른혈	ᇤ	1 Never Married 2 Marr	ed 1	Armed Ford	:as? 21 No						can, etc.)		Black, V	Vhite, etc.	
036	o la	Ď	3 ☐ Widowed 4 ☐ Divorced	1	f Yes, Give rear or Da	)		1 ☐ Yes 2	2LXNo	Specify:			,	Specify:	White	
21215-0036 od within 72 hours after death with the Maryland	"neture!", or items 23s or 28s-f show	Completed	15. Decedent (Specify only highes				16a. Dece	dent's Usua kind of wor	I Occupa	ation	t of working	,	16b. Kir	d of Busin	ess/Industry	
121	- 70	npie	Elementary/Secondary (0-12)	T	College (1-	4or 5+)	life.	DO NOT us	e retired	) -	. c. woming	<b>'</b>				
d 21	Hygian other th	5	8				D	isab]	Led					Disa	bled	
pu #	d a	Be	17. Father's Name (First, Middle, James T. Go1		+ h							First, Middle,		Sumame)		
aryla	Mental arked o	ည										. Per				
Maryland		10 1	19a. Informant's Name/Relations				D					Rou <i>te Numbe</i> .te Pl				
	m 27 m 27 her tr		Stephanie Gi	lroy	<u>/Coo</u>		tor Telace of Dispo			1000					20695	
Ore les	0		20a. Method of Disposition  X Burial 2 Cremation	3 □Remo	val from S		cemetery, cre-	matory or or	ther place	e)	Da				y or Town, State	
tim	tent: jury		4 □ Donation 5 □ Other (S			Ch: M0094									,Marylan	d
Baltimore,	Department of Important: If II any Injury or one		21. Signature of Funeral Service	icensee	- / //	110034	2	ARTH	ART	=ECH	OLS	FUNER	AL F	HOME,	P.A.	
ш .	. O = # 0		Naw (	. / <	noe			211	ST.	_MAR	Y'S	AVE.	LA_I	PLATA	MD 2064	+6
			23a. Part1. Enter the disease, or shock, or heart failure. List	only one ca	dse on ea	ch line.	th. Do not en		,	-		respiratory ar	rest,	1	Approximate Interval Betwee Onset and De	
PI	hysician		Immediate Cause (Final disease or condition	/	MEI	asta	ICC	A20	المحسلة	2MI	B 0	600	010	,	XMOW	
	Medical		resulting in death)		Due to (c	or as a consec	uence of):				1					
-	xaminer		Sequentially list conditions.	b												
B. D	- <del></del> -	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	,	Due to (c	r as a consec	uence of):									
Por spin	and I-trans	cam	that initiated events resulting in death) Last	с	Dua to /a											
I Records, P.O. Box 68760, Control The law requires that the deeth certificate be executed.	lysicien and he burial-transit	Ē			Due to (c	or as a conseq	(uerice or).									
8760	physics the t	dical		d d												
× 6	attending ph for use as ti	/Med	IF FEMALE:	230 1	t vas outc	ome ot pregna	ancy									
Box	atten for us	Physician/M	23b. Was decedent pregnant in the past 12 months?		1 Live bir	th 2 Feta	al death 3	Ectopic pr					2	3d. Date of Month	delivery Day Ye	ar
O. et	by the a	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown		9 Unknov	int at time of o wn	Jean St	Other (sp	ecity/							
٠. E	ad by detac		Part II. Other significant condition	ns contribu	utina to dea	ath but not res	sulting in the u	nderivina c	ause give	en in Part I		23e. Did to	obacco us	se contribu	te to the cause of dea	ath?
Records,	signed b	D P						, ,				101	res 2[	]No 3[	Probably 4 Un	known
Ö	should	ete										04- 146-		045 144		- 1-61-
Rec Se Se Se Se Se Se Se Se Se Se Se Se Se	has Je 2 s	Completed										24a. Was autop		prior deat	e autopsy findings av 1 to completion of cau th?	ise of
<u>a</u>	icete ha											1 ☐ Yes	2 No	10		
vision of Vital	certifice irector, p	Be	25. Was case referred to medical examiner?	Hospi	ital:				Othe	or A		Check only o				
o o	this aldii	ဥ	1 ☐ Yes 2 No  27. Manner of Death		1 🗀 !n		28b. Time o		/A	4 NINU		e 5 Resid			Specify)	
C E	h. After thi funeral	lo l	1 KNatural 5 ☐ Pendin	9	(Month	f Injury , Day Year)	Injury	м	8c. Injury Work	k? Yes 2 □		d. Describe i	iow injury	occarred		
isic	death. c <b>tor</b> : A y the fu	cat	2 Accident investig	not be	9a Place	ot Injury - At h	ome farm et			165 2		If Location (5	Street and	Number o	or Rural Route Numbe	or.
5 8	Direction by	Certification:	4 Homicide determ	ined	buildin	g, etc. (Special	fy)	reot, ractory	, onlo			City or Tov			, Transa Trodio regimbe	",
To the Hospital	within 24 hours after deatl To the Funeral Director: completely filled in by the		29a. Certifier 1 Certifyin	a Physicie	n: To the	best of my kno	owledge deat	h occurred	at the tim	ne, date an	nd place an	id due to the	cause/s)	and manne	er as stated	
HO	24 h Fun stely	Medical		Examiner:		sis of examina									due to the cause(s)	
d d	o the	Me	29b. Signature and title of certifie			N		290	License	e number			29d. Date	signed (N	fonth, Day, Year)	
	· s = 0		1 mm	14	11/2	1/2	m	) "	1	7	0(.)	79		10/1	7/16.	
	\		30. Name and aggress of person	with combi	eted cause	of death (Iter	n 23a) (Tuna	Print)	L	<u> </u>	- 0 (	- 1	0		7	
	\		CIVE AIM ISO	- I I	PAT	Henry Charles	M. I	\\\	1121	LOC	12 V.	- MI	V.	20	603	
	Sta	te	31. Date filed (Month, Day, Year)	0000	32.	gistrar's Signa	atura	d 21	* 1 J			, , , , ,	``	-		
	Regist		31. Date filed (Month, Day, Year)	2 2006	1	WHO .	Sto by	American Comment								

		`	FOR	State of Marylan	-			nd Mental Hy	giene	2000	01070
			1 - State Registrar		Cei	rtificate	of Death		Reg. No.	2000	34878
Н	Physici	an	Decedent's Name (First, Middle, Last)					2. Date of Do Month	Day		3. Time of Death
7	/Medic	al	Shirley T. Gr	reen		4h Cih, T	own, or Location of I			27,2006 County of Death	7:59A M
	Examir	er			7			Death			
	Funeral		Southern Maryla 5. Social Security Number 6. Sex	7. Age (In yrs.		If Under 1		Hrs. 8. Date of Bi	rth	cince Go	eorges place (State or Foreign ptry)
	Director		577-64-4560	M 20%F	63 Yrs.	Months	Days Hours	Min. (Month, D. Sept.			sh.,DC
	pu ,		Usual Residence of Decedent  10a. State 10b. County	10c Cit	ty, Town or Lo	ostion					Od. Inside City Limits
	ehov	ក								'	1 X Yes 2 □ No
	28e-f	ect	Md. PG  10e, Street and Number		Suitl	and 10f. Zip (	Code		10a. Citi	izen of What Cour	ntry?
	with or	<b>Funeral Director</b>	6030 Lucente Ave	20110		101. 2.0					•
	me 23	era		2. Was Decedent Ever in U	.S. 13.	Was Decede	20746 ent of Hispanic Origin	? (Specify Yes or N		ited St 14. Race - Americ	can Indian,
9	atter or ite	F	1 ☐ Never Married 2 🔀 Married	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give		it Yes, speci 1 □ Yes 2	fy Cuban, Mexican, F  No Specify:	Риепо Нісап, етс.)	1	Black, White,	etc.
8	Era,	d by	3 Widowed 4 Divorced	Year or Dates:		10 165 2	A NO Specify.			Specify: Bla	ck .
21215-0036	within 72 hours atter death with the Maryland ene. then "naturel", or itema 23a or 28e-f ehow the Madical Examinar must be notified at	Completed	15. Decedent's Educa (Specify only highest grade		(Give		Occupation k done during most o	f working	16b. Ki	ind of Business/Inc	dustry
7	withir Bne. then	E C	Elementary/Secondary (0-12)	College (1-4or 5+)		Nurse				Private	7
0 0	Hygi Hygi other		17. Father's Name (First, Middle, Last)			NULDO		Name (First, Middle			
<u>a</u>	lid be lental rked rked ric ev	To Be	Robert Wright				Dore	othy Smi	th		
Maryland	and M		19a. Informant's Name/Relationship (Type					or Rural Route Numb	er, City o	r Town, State, Zip	Code)
Σ	is 1 and 2 should be tiled within 72 hours atter death with the Marylan of Heelth and Mental Hyglene. Item 27 ie marked other then "naturel", or itema 23a or 28e-f ehow other treumatic event, the Medical Examinar must be notified at		Nicholas L. Gree	n/husband	Suit	land,	ente Aver	nue 746 Date			
Baltimore,			20a. Method of Disposition 1 Structure 2 ☐ Cremation 3 ☐ Re	1 /	Place of Dispo cemetery, crer	natory or oti	e of her place)	Date	20c. Lo	cation - City or To	own, State
<u>=</u>	permit, Page Department importent; If eny injury or once.		4 ☐Donation 5 ☐Other (Specify)		dar Hi	.11 C	em. 11	/7/06	Sui	tland,	Md
Bal	permit. Departr importe eny inje		21. Signature of Funeral Service Licenses	1	- 72	O 1 O	Address of Facility	Hodges &	Ed	wards F	'.H.
			23a. Part1. Enter the disease, or complic	ations that caused the deat						itiand,	Md.20746 Approximate
	Dhuninian		strock, or heart failure. List only one Immediate Cause (Final	cause on each line.							Interval Between Onset and Death
1	Physician /Medical		disease or condition resulting in death)	Due to (or as a conseq		BIAL	INFA	CCFION.			
	Examiner		Sequentially list conditions b.								
Λ	₽ ≅	ner	I any, leading to minipolate cause. Enter Underlying	Dualty (or as a gov ree)	wante of):						
NA	and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseq	uanna att:						
8760,	cate be executed oblysicien and the burial-transit	ai E		Doe to (or as a conseq	derice or).						
687	phys s the	dicai	, d.								
Box (	eath certitic ettending p	√Me	IF FEMALE: 23b. Was decedent pregnant	c. If yes, outcome of pregna						23d. Date of delive	Эгу
ă	that the death cer ned by the ettendin detached tor use	iciai	in the past 12 months? 1 ☐ Yes 2 ☑ No	1 Live birth 2 ☐ Feta 4 Pregnant at time of d		Ectopic pre Other (spe				Month	Day Year
P.O.	by the tache	hys	9 Unknown	9□ Unknown							
Š,	res tha igned be de	by Physician/Med	Part II. Other significant conditions conti	ributing to death but not res	ulting in the u	nderlying ca	use given in Part I.				ne cause of death?
ord	w require been sig should t	Completed	DIABETES					- 10	Yes 2	No 3 Prob	bably 4 Dunknown
ec	law r	npie	HYPERTENTIO	ν				24a. Was	psy	24b. Were auto	psy findings available mpletion of cause of
<u> </u>	: The	Con	LIPID DISOR	DER				1 ☐ Yes	ormed? 2 No	death?	2 0 No
<u> </u>	ysician: The lav is certificate hes director, page 2	Be	25. Was case referred to medical examiner?	espital:				Death (Check only			
ō	Physical dil	 T:	1 Yes 2 No	28a. Date of Injury	FR/Outpatien 28b. Time of		A 4 Nursi Bc. Injury at Work?	ng Home 5 ☐ Res 28d. Describe			y)
O	th. : Afte	tion	1 Natural 5 Pending 2 Accident Investigation	(Month, Day Year)	Injury	М	Work? 1 ☐ Yes 2 ☐ No	)		•	
Division of Vital Records,	Atter actor by the	ifice	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At he building, etc. (Specif.	ome, farm, str	eet, factory,	office	28f. Location ( City or To	Street and	d Number or Rura	I Route Number,
۵	rs afte	Certification;	4 D Homeda	building, etc. (Specin	<i>y</i> ,			Ony or 10	war, Otato,	/	
	Tospi 4 hour Funer ely till	edicai	(Check only 2 Medical Examine	cian: To the best of my kno er: On the basis of examina	wledge dasti	vestigation,	the time, date and; in my opinion, death	tiana, and dua to the occurred at the time,	date and	and manner as st place, and due to	o the cause(s)
	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours affect death.  To the Funeral Director: After this certificate hes been signed by the ettending p completely tilled in by the funeral director, page 2 should be detached for use as	Medi	29b. Signature and title of certifier	and manner stated.			License number			e signed (Month,	
	7 × 1		M = 2 : -	. 7			50689			2712	•
7	k		30. Name and address of person who com	note a cause of death (Item	n 23a) (Tvne	l l			. ,		
	4		SULTHERN MARYL	V							0 20735
	Sta	te	31. Date filed (Month, Day, Year)	32. Redistrar's Signa		A. A.	*				
	Registr	ar	MAN O S CI	100 Marian	AS A	A STATE OF THE STA					

			For State	State of Maryla			t of Health and e of Death	Mental H		006	21.070
		橅	Registrar  1. Decedent's Name (First, Middle, Last)		06	TillCall	e or Death	2. Date of I	Reg. No.	000	3. Time of Death
	Physici /Medio		JOHN WILLIAM	GIRD				CC+OD	er 25	2000	9:40P M
	Examir		4a. Facility Name (If not institution, give s		0.0	4b. City,	Town, or Location of De	ath	4c. C	County of Death	36
	Eupovál		5. Social Security Number 6. Sex	7. Age (In yrs	( last birthday)	If Under	YIUTU 1 Year   If Under 24 H	rs. 8. Date of E	Birth	9. Birtho	place (State or Foreign
	Funeral Director		033-38-8677 X	№ 2□F 57	Yrs.	Months	Days Hours Mi	n. (Month, i	Day, Year)	Coun	SACHUSETTS
_	and		Usual Residence of Decedent  10a. State 10b. County	10c. C	ity, Town or Lo	ocation			7 . 5		0d. Inside City Limits
	h the Marylar r 28a-f ehow	ţō	MARYLAND CHARL	FS	LA PL	א ידי א					1 <b>X</b> Xes 2 □ No
_	ith the	Director	10e. Street and Number			10f. Zip	Code		10g. Citize	en of What Coun	itry?
Q	ath w		6560 TIP HILL R				20646			U.S.A.	
= 10	rs after death with ", or Itema 23a or	Funeral	11. Marital Status 1 ☐ Never Married 3€Married	12. Was Decedent Ever in t Armed Forces? 1 ☐ Yes 2 ☑ No		Was Deced If Yes, spec	ent of Hispanic Origin? ofy Cuban, Mexican, Pu	(Specify Yes or I erto Rican, etc.)	No- 12	<ol> <li>Race - Americ Black, White,</li> </ol>	
	ours a	b	3 Widowed 4 Divorced	If Yes, Give X Year or Dates:		1 ☐ Yes 2	XXIX Specify:		S	Specify: WH	ITE
	natu	Completed	15. Decedent's Edu (Specify only highest grade		16a. Dece	dent's Usua kind of wor	ll Occupation rk done during most of w e retired)	vorking	16b. Kind	d of Business/Inc	dustry
212	y withii jiene. r then the M	dmo	Elementary/Secondary (0-12) 12	College (1-4or 5+) 5			ANALYST		SME	CO	
10 E	al Hyg	BeC	17. Father's Name (First, Middle, Last)					lame (First, Midd			
Maryland	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene.  le marked other then "natural", or itema 23a or 28a-f show aumatic event. The Weultal Examiner must be notified at	ို	JOSEPH PETER G			<del></del>		ENE POI			
Mai	d 2 st Ith and 27 ie n traun		19a. Informant's Name/Relationship (Ty) PAT GIRD-WIFE	pe, Print)		_	(Street and Number or HILL ROA		-		
ē.	s 1 and 2 of Health Itam 27 i		20a. Method of Disposition		Place of Dispo	sition (Nam	ne of	Date Date		ation - City or To	
Baltimore,	Pages ment of hant: If Its ury or of		1 ☐ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	METROI	POLITI	AN C	REMATORY	10-27-0	6 AL	EXANDR	IA, VA
Balt	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service License	P <sup>®</sup> ✓ MO(	1479 22	2. Name an	d Address of Facility ND FUNERA				
			23a. Part1. Enter the disease, or compli	cations that caused the dea							Approximate
	Physician		shock, or heart failure. List only or Immediate Cause (Final disease or condition	e cause on each line.		atic		State		nome	Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a conse		7-16	1 .0)	1416	Car	e nerves	
	Lammer	<u></u>	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	. Due to (or as a conse	quence of):						
Res	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,						
00 V	cate be executed oblysician and the burial-transit		resulting in death) Last	Due to (or as a conse	quence of):						
8760,	cate phy:	dical									
Box 6	eath certific attending p I for use as	n/Me	IF FEMALE: 23b. Was decedent pregnant 2:	3c. If yes, outcome of pregr					23	d. Date of delive	erv.
	ed for	by Physician/Me	in the past 12 months? 1 Yes 2 No	1☐Live birth 2☐Fet 4☐Pregnant at time of 9☐Unknown		Ectopic pre Other (spe					Day Year
P.O.	that the de ted by the a detached i	Phy	9 ☐ Unknown Part II. Other significant conditions con		culting in the u	adoshina es	nues annos in Rost I	230 Dia	I tobacco uso	a gogtribute to th	ne cause of death?
of Vital Records,	8 5 6		Tanni digililibani bonali bona	thousing to double out hot to	Sulling III the th	idenyang ce	iuse giver in Pairi.		Yes 2		
000	aw requires been si	Completed						24a. We	is an	24b. Were autor	psy findings available inpletion of cause of
200	The lav	Com						aut per 1 Yes	formed?	prior to con death? 1 \( \sum \text{Yes}	
Vita	yeicien: 7	Be	25. Was case referred to medical examiner?	ospital:				eath Check only			
	Phye r this eral dir	. To	1 Yes 2 No	1 Pinpatient 2L	ER/Outpatien		A Other: 4 Nursing Bc. Injury at Work?	Home 5 Re			"
ö	tending Ph leath. tor: After th the funeral	atlor	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	Injury	м	Work? 1 ☐ Yes 2 ☐ No				
Division	br Atte fter de jirecto n by th	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At I building, etc. (Spec	nome, farm, str	eet, factory,	, office	28f. Location City or T	(Street and i	Number or Rural	l Route Number,
	To the Hospital or Attend, within 24 hours after death To the Funeral Director: / completely filled in by the fi		29a. Certifier 1 V Certifying Phys	ician: To the best of my kn	owledge death	a accurred a	at the time, date and pla	an and due to th	0.00000(0)		
	ne Hos n 24 h ne Fur pletely	edical	(Check only 2   Macical Examinations)	ier: On the pasis of examin and manner stated.	ation and/or in	estigation,	in my opinion, death oc	curred at the time	e cause(s) and p	lace, and due to	the cause(s)
	To the within 2 To the complet	Ň	29b. Signature and title of certifier			29c.	License number		29d. Date	signed (Month, L	Day, Year)
			P Consumer				いけついつ	1	10	1261	06
	8		30. Name and address of person who co	mpieted cause of death (Ite	т 23а) (Турв	Th	3328 0	ia luga	n Ha	450 K	D 20107
	Sta		3 . Date filed (Month, Day, Year)	32 Redistrar's Sign	ature				-ACAC	40 1 /3º	
	Registr	ar	NAV a a 26	Hih lan	18 1	Market L.	-				

State of Maryland / Department of Health and Mental Hygiene UU b

Certificate of Death 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 1050AM GRE /Medical 4c. County of Death 4h City Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Hanover Upperco If Under Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Min 1 2M 2□ F 198-30-2340 Yrs. Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location r than "naturel", or Items 23a or 28e-f show The Medical Examiner must be notified at 1 ☐ Yes 2 DNo Director Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 721 anover Funeral Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: within 72 hours after 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Whit <u>م</u> 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Gress Construction Elementary/Secondary (0-12) College (1-4or 5+) Dwner/Operator Company 12 n and Mental Hygie 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) G1055 W. dred Norman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2:
Department of Health at
Importent: If item 27 is
any njury or other trau 11/07 Rep (a Rd 131 1dge Gress MION Jason Baltimore, 2 . Location - City or Town, State 20a. Method of Disposition comotory, cromatory or other
Tom L. Geisel
Liema tor ium 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Chambershurg 10/18/06 \* 4 ☐Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Howard L. Sinks Funkabl 21. Signature of Funeral Service Licenses 875 LINCOLN WHY EAST Me CONNELLSOUSE, FA M01035 17233 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate and Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence Examine The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of) physician Physician/Medical the y the attending particles of the assistance of the attended for use as 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 4☐Pregnant at time of death signed by the at id be detached for 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 ☐ Unknown o 9☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peeu 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has certificate 1 ☐ Yes 2 No of Vital To the Funerel Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 1 🗆 Yes 1 Inpatient 2 ER/Outpatient 3 DOA ٩ 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: 1 Natural To the Hospitel or Attending 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide within 24 hours after To the Funerel Dire Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of gertifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) VMON BRIDGE 104N 31. Date filed (Month, Day, Year) 32. Registrar's Signature State OCT 27 2006

Registrar DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] [] [ Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Octonth 17, **Physician** 2006 7:15 A.M GOLDBERG Sadye /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 10820 Margate Rd. Silver Spring Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 □XF 86 579-22-9443 Yrs Director May 12, 1920 Minnesota Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heelth and Mental Hygiene. Intent of Heelth and marked other then "natural", or items 23s or 28s-f ehow 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits injury or other treumatic event, the Medical Examiner must be notified at Silver Spring MD Montgomery 1 ☐ Yes 2 No **Funeral Director** 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 10820 Margate Rd. 20901 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black. White, etc. 1 ☐ Yes 2 Tho If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ▼ No Specify: Completed by 3√ Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ann Miller Louis Feldman 19a. Informant's Name/Relationship (Type, Print)
Lois Hollander / daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5238 Farm Pond Lane, Columbia, MD 21045 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Department of important: if eny injury or once. Mt. Lebanon Cemetery Oct. 19, 2006 Adelphi, MD 4 ☐ Donation 5 ☑ Other (Specify) 21. Signature of Fundami Service I ca 22. Name and Address of Facility Torchinsky Hebrew Funeral Home 254 Carroll St., NW, Washington, DC 20012 23a. Part1. Enter the disease, or complication shock, or heart failure. List only one cay that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, so on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Interstitial Lung Disease **Physician** 16 months disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed use as the burial-transit attending physicien and for use as the burial-traresulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Dav Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ₩ No 9 ☐ Unknown ate hes been signed by the a page 2 should be detached to 9☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Cerebrovascular Disease 1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown Atrial Fibrillation 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? To the Hospins.
within 24 hours efter death.
To the Funeral Director: After this certificate
monoletely filled in by the funeral director, par this certificate 1 ☐ Yes 2 ☐ No 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death | Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 ☐ Yes 2 ☒ No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 XNatural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 18 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Oct. 17, 2006 D33159 Kevess Collen M.D. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

Ruth Kevess-Cohen, 8700 Georgia Ave., Silver Spring, MD 20910

32. egistrar's Signature

2006

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			1 - For State Registrar	ate of Maryl			of Health of Death			giene	16	31.882
	Physici /Medio		Decedent's Name (First, Middle, Last)	lter	Hipkins	5			2. Date of Dea Month October	ath	)6ªr	3. Time of Death 4:00 PM
7	Examin		4a. Fecility Name (If not institution, give street 5750 Butterfly I			4b. City, To	own, or Location Frede	erick		4c. County of		lerick
	Funeral Director		5. Social Security Number 6. Sex 15-36-7193		yrs. last birthday) Yrs.	If Under 1 Months I	Year If Under Days Hours	Min.	8. Date of Birth Octob	, Year) 915	9. Birthpl Mary	ace (State or Foreign Nand
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	th with the 23a or 28 ist be not	ai Director	10e. Street and Number 5750 Butterfly Lan	e		10f. Zip C				10g. Citizen of W	hat Coun	try?
980	permit. Pages 1 and 2 should be filed within 72 hours atter death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Intercret: it term 27 is marked other then "naturel", or items 23a or 28a-f show any njury or other traumatic event, the Medical Exemples rules the notified at once.	Completed by Funeral	1 Never Married 2 Married 1	as Decedent Ever in med Forces? Yes 2 XNo Yes, Give ear or Dates:	'	Was Deceder f Yes, specify 1 ☐ Yes XX	nt of Hispanic Or Cuban, Mexica No Specify	in, Puerto R	ify Yes or No- ican, etc.)	Black	- America , White, e	etc.
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Baltimore,	permit. Pages I Department of H Important: If Ite any Injury or ot ance.		20a. Method of Disposition  1 X Burial 2 ☐ Cremation 3 ☐ Remov 4 ☐ Donation 5 ☐ Other (Specify)	al from State M	b. Place of Dispo cemetery, cren bunt Olive	t Cenet	ery Oct	. 25, 2	2006	Frederic		wn, State MD
B B	Department of the control of the con		21. Sign wur of Funeral Service Licensee	Hast	1100 1	06 Eas	Address of Faciliand Bast Church	1 Stre	et. Fr	ederick.	MD	
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DIVISION	투교통교	Certification:	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	(Month, Day Year Place of Injury - A building, etc. (Spe	t home, farm, stre	M eet, factory, o	Work? 1 ☐ Yes 2 ☐		f. Location (Si City or Town	treet and Number n, State)	or Aural	Route Number,
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	10		30. Name and address of person who complet	ed cause of death (I	Item 23a) (Type, I	TA	JE F	REDE	RICK	MD -	217	2
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	Sta Registra	_	31. Date filed (Month, Day, Year)  OCT 2. 7 2006	He. 32. Re	gistrar's Signatu	IĐ							

State of Maryland / Department of Health and Mental Hygiene [] [] [ T State
Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** 12:00P M TERESA EGAN HALLAM 14 2006 October 0 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Renaissance Gardens Nursing Home Silver Spring Montgomery 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1 ☐ M 2 🖾 F Months Days Hours 90 Director 213-38-0488 1916 Rhode Island 17, Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Modical Examinar must be routiled at 1 ☐ Yes 2X No Director Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 3118 Gracefield Road, Apt CC-419 or Items 23a 20904 U.S.A. Funerai 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 2 should be filed within 72 hours after on and Mental Hygiene. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: à If Yes, Give Year or Dates: Specify: White 3 X Widowed 4 □ Divorced eted 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Comple Elementary/Secondary (0-12) College (1-4or 5+) 3 Years Housewife Domestic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Joseph Egan Mary Segerson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health (Important: If item 27 Is any injury or other tra Philip Michael Hallam/Son 310 Eldrid Drive, Silver Spring, Maryland 20904 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages ' 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Gate of Heaven Ceme. 10/19/2006 Silver Spring, Maryland ` 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility HINES-RINALDI FUNERAL HOME, INC. 11800 New Hampshire Ave, Silver Spring, MD 20904 23a. Part1. Enter the dise shock, or heart failur ise, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) tou /Medical Due to (or as a consequence of): Examiner Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed Due to (or as a consequence of): attending physician a for use as the buriat-Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. | the 9 Unknown 9 Unknown ģ signed to Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. ģ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown should I Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 1 ☐ Yes 2 ☐ No 1 🗌 Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 🗌 Yes 23 No 1 Inpatient 2 ER/Outpatient 3 DOA After thi 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending To the necessarier death.

Vithin 24 hours after death.

To the Funeral Director: After the funeral on by the funeral or the f investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 🗌 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) DO043375 20 20904 30. Name and a who completed cause of death (Item 23a) (Type, Print) Gracefield 3110 Registrar's Signature 31. Date filed (Month, Day, Year) State 19 2006 Registrar

	1	State of Maryland / Department of F State Registrar  State of Maryland / Department of F Certificate of		Mental Hygie	/	34885
		Decedent's Name (First, Middle, Last)		2. Date of Death		3. Time of Death
Physiciar /Medica		Patrick B Herrington		Month Uct	Day Year	6 1418 M
Examine			r Location of Death		4c. County of Deal	
		Howard County General Hosp Co	lumbial	Mn	Howar	d
Funeral		5. Social Security Number 6. Sex / 7. Age (In yrs. last birthday) If Under 1 Year	if Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye	9. Birt	hplace (State or Foreign
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pu .		Usual Residence of Decedent				
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88a-f	Director	MD. HOWARD COLUM	BIA			1 ∑ Yes 2 ☐ No
or 2	2	10e. Street and Number 10f. Zip Code		10g.	Citizen of What Co	ountry?
death with the Maryland rms 23e or 28e-f show rmust be notified at	-		.046		U.S.A.	
e m de	runerai	11. Marital Status  12. Was Decedent Ever in U.S. Amed Forces?  13. Was Decedent of H If Yes, specify Cuba	lispanic Origin? (S) an, Mexican, Puert	pecify Yes or No- to Rican, etc.)	14. Race - Ame Black, Whit	
1215-0036 within 72 hours after and then fracturel; or the canding Examine	Dy L	1 Never Married 2 Married 1 Never Married 2 Married 1 Never No 1987 - 1 Yes 2 No 1987 - 1 Yes 2 No 1987 - 1 Yes 2 No	Specify:		Specify:	A CIT
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withi theorem	Ĕ	Elementary/Secondary (0-12)  College (1-4or 5+)  4  U.S. NAVY	-,		DEFE	JCE
be filed that Hyging of other event, I		17. Father's Name (First, Middle, Last)		ne (First, Middle, Mai		NOL
d d be and a d be a d b	D D	SAMUEL HERRINGTON	Τ.	OTTIE	ROCHELLE	
Maryland 21215-0036 d 2 should be filed within 72 hours after death with the Marylan th and Mental Hygiene. The marked other then "nature!", or items 23s or 28s-1 show treumetic event, the Medical Exam for must be notified at	0	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street				7in Code)
		RITA HERRINGTON/SISTER P.O. BOX 1107				
other to	-	20a. Method of Disposition 20b. Place of Disposition (Name of			. Location - City or	
0 80 = 5		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State	1			
프N 교 된 원광 .	-	4 Donation 5 Other (Specify) MARYLAND VETERANS 21. Signature of Funeral Service Ocensee 22. Name and Addre				
Popariti Importe ony Inju		CHAMBERS F	UNERAL HO	OME & CREM	ATORIUM,	P.A.
9.1	+	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying			<del>-</del>	20 / 3 / Approximate
		shock, or heart failure. List only one cause on each line.	ig, such as cardiac	or respiratory arrest,		Interval Between Onset and Death
Physician		Immediate Cause (Final disease or condition resulting in death)  a. Ventrucular fibri	Hatio	2		
/Medical Examiner		Due to (or as a consequence of):				0
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ed sit	Examine	Sequentially list nonditions if any, leading to immediate cause. Einer Underlying Cause (Disease or injury				
and I-trar	Xan	that initiated events c. resulting in death) Last Due to (or as a consequence of):				
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P.O. BOX 6i het the death certific d by the attending p letached for use as	3	IF FEMALE: 23b. Was deceded program 23c. If yes, outcome of pregnancy				
Bath of author for us	2	in the past 12 months?  1 Live birth 2 Fetal death 3 Ectopic pregnancy	1		23d. Date of del Month	ivery Day Year
. 0 00 -	38	1 Yes 2 No 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown				· ·
		Part II. Other significant conditions contributing to death but not resulting in the underlying cause give	en in Part I	23e Did tobac	co use contribute to	the cause of death?
ecords, Plaw requires thet as been signed to 2 should be detailed.	ລ		J	1 □ Yes		
w requirements	Completed					, A
lec law has t e 2 s	<u>.</u>			24a. Was an autopsy	prior to d	topsy findings available completion of cause of
The lav	5			performed Yes 2		2 <b>X</b> /No
	Δ :	25. Was case referred to medical examiner?		ath (Check only one)		
F y sign		1 ☐ Yes 2 📉 No Hospital: 1 ☐ Inpatient 2 🗶 ER/Outpatient 3 ☐ DOA	4 🗆 Huising H	lome 5 Residence		cify)
ing F	5	27. Manner of Death 1 SaNatural 5 Pending 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Wor		28d. Describe how i	injury occurred	
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DIVISION OF all or Attending Phy alter death. I Director: After this d in by the funeral d	Certification	4 Homicide  3 Social not be determined  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Stree City or Town, S	t and Number or Ru tate)	ıral Route Number,
2 5 2 9 9 C	2					
Hospital Puners Funeral Italy filled	e cica	29a. Certifier (Check only (C	ne, date and place pinion, death occu	), and due to the caus irred at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)
within 2 To the complet		one) and manner stated				
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911		in the land to the land	. 50 00	· /	0/12/0	6
		30. Name and address of person who completed thus of death (Item 23a) (Type, Print)	1 4.	ita "	0/12/0 Vambia	h. 12 -
		31. Date filed (Month, Day, Year)  32. Registrar's Signature	11111	11101	Junsia	MD 21044
State Registra		29b. Signature and title of certifier  29c. Licens  30. Name and address of person who completed but of death (Item 23a) (Type Print)  31. Date filed (Month, Day, Year)  32. Registrar's Signature				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 34886 Certificate of Death 3. Time of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician Doretta Mae Harrell October 18, 2006 0210 A /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Coastal Hospice at the Lake Wicomico Salisbury If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1 ☐ M 2 😾 F 59 Yrs Director March 23,1947 Pennsylvania 215 52 7118 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f ehow item 27 is marked other than "naturel", or items 23a or 28a-f shov other traumatic event, the Modical Examinar must be notified at 1 ves 2 No Maryland Worcester Ocean City Directo 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 10101 Pebble Ct. 21842 U.S.A. 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status e filed within 72 hours after. Il Hygiene. other than "naturei", or Itel 1 Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2 No Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Director of Sales Hotel permit. Pages 1 and 2 should be file.
Depertment of health and Mental Hygis important: if item 27 is marked any injury or other town 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Fred Lynch, Sr. Doris Mathias 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10101 Pebble Ct. Troy Harrell Ocean City, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2x☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cape Henlopen Crem. 10/18/06 Frankford, DE 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 108 William St. The Burbage Funeral Home 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Berlin, MD Onset and Death Immediate Cause (Final disease or condition resulting in death) Metastatic Pancreatic Cancer **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed physicien and the burial-transit Due to (or as a consequence of): Physician/Medical use as IF FEMALE If yes, outcome of pregnancy 1☐Live birth 2☐Fetal de 23b. Was decedent pregnant 23d Date of delivery 2 Fetal death 3 DEctonic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No
9 ☐ Unknown Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ page 2 should be 1 ☐ Yes X ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificete has autopsy performed? 1□ Yes 27□ No 1 Yes 2 No To the Hoepital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifice Be ( funeral director, 25. Was case referred to medical 26. Place of Death (Check only one, Hospital: 1 ☑ Inpatient examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ▼No 3 DOA 2 ☐ ER/Outpatient 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification; Natural Natural 5 Pending Injury 1 Tes 2 No 2 Accident investigation 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the and manner stated. Medical (Check only xination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D26278 10-18-06

Registrar DHMH 17 Rev 1/2001

State

BA 5

3altimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

P.O. Box 1733 Salisbury, MD 21802

Coastal Hospice

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

David E. Cowell, M.D.

31. Date filed (Month, Day, Year)
OCT 19 2006

			1 - For State Registrar	State of M	aryland	-	artment of H		and M	_	giene Reg. No2 ()	06	34887
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	/Medic Examir		4a. Facility Name (If not institution		hnson Jr		4b. City, Town, or	Location o	of Death	OCTOR		ty of Death	100
				s Manor Nursing					mberl			Alle	
	Funeral Director		5. Social Security Number	6. Sex 7. A	ige (In yrs. Ia	ast birthday) Yrs.	If Under 1 Year Months Days	If Under a	24 Hrs. Min.	8. Date of Birt (Month, Da		9. Birth	place (State or Foreign ntry) Maryland
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	death ms 2	nera	11. Marital Status	ngine House Ro'  12. Was Deceden Armed Forces	t Ever in U.S	6. 13.	Was Decedent of His If Yes, specify Cubar			cify Yes or No	- 14. Ra	ce - Amen	can Indian,
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	and 2 lealth a m 27 Is		Larry John	nson - Son			29 Hawtho						
Baltimore,	of He of He		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation	3 ☐ Bernoval from State		ace of Dispo metery, crer	sition (Name of matory or other place	9)		etober 27.	20c. Location	- City or To	own, State
tim	permit. Pages Department of I Importent: If its any injury or o		*4 □Donation 5 □ Other (Sp	pecity)			Veterans Cer			2006	Flint	stone, N	Maryland
Bal	permit. Departn Importe any inju		21. Signature of Funeral Service I	icensee		22		Eichhor	n-Mc	Kenzie Fu			
			23a. Parr . Inter the disease, or ship or heart failure. List	cooplications that cause	ed the death.	Do not ent	er the mode of dying	Fast Mag, such as	ain Str cardiac o	reet, Lona	coning, M	D 2153	Approximate
	Physician	Ш	Immediate Cause (Final disease or condition	SPICS	/ 07	7/5		CE	-			_	Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or a	s a conseque	ence of):	- / / / 9		10.				/EAR
	LXammer	_	Sequentially list conditions,	b. Due to (or a	s a conseque	ence of):							
П	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		o a oonooqa	01100 01).							
o,	ate be executed hysician and the burial-transit		resulting in death) Last	C. Due to (or a.	s a conseque	ence of):					·		
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Box	that the death cer ed by the attendir detached for use	iciar	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live birth 4 Pregnant a	2 Fetal	death 3	Ectopic pregnancy Other (specify)					ate of delive onth	Day Year
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) t	Physician: this certific ral director.	To B	examiner? 1  Yes 2	Hospital: 1 ☐ Inpat	ient 2 🗆 E	R/Outpatien	t 3 DOA Othe	r W		ne 5 Resid		her (Specif	y)
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Ο̈́	el or / s efter el Dire	Certification;	4  Homicide	building, e	itc. (Specify)		,		1	City or Tow	m, State)		
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	To the Ho within 24 To the Fu	Medi	one)  29b. Signature and title of certifier	and manner s	tated.		29c. License						· ·
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1	7 -1 VA		30. Name and address of person v	who completed cause of	death (Item :	23a) (Type.		10			CIODE	. 00 -	,0000
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	."		ForaMFND#23a per PHY. Registrar 10/18/06 AACO I  1. Decedent's Name (First, Middle, Last)	State of Marylan HEALTH DEPT. CMH	Cartificata		Rag. N	/IIIh	34889
	Physicia /Medic		Josephine T. Keen				Month D	)ay Year 5 2006	8-56 AM
	Examin		49 Facility Name (If not institution, give si	reet and number ME)	ICAL 4b. City. Tox	wn, or Location of Death	1/= 1	County of Deat	Rundel
	Funeral Director		Social Security Number 6. Sex	7. Age (In yrs. 75		Year If Under 24 Hrs. Pays Hours Min.	8. Date of Birth (Month, Day, Yea Jan. 21,	9. Birti Co 1931 Per	hplace (State or Foreign untry) unsylvania
	D		Usual Residence of Decedent  10a, State 10b, County		y, Town or Location				10d. Inside City Limits
	deeth with the Maryland me 23a or 28a-f ehow rmust be notified at	ector	MD Anne Aru	ındel	Millersvill		100.6	Citizen of What Co	1 ☐ Yes 2 🐼 No
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036	ours after deeth with the Marylan raf', or iteme 23a or 28a-f ehow Examinar must be notified at	Ď	11. Marital Status  1 Never Married 2 Narried 3 Widowed 4 Divorced	2. Was Decedent Ever in U. Armed Forces? 1 □ Yes 2 ☑ No If Yes, Give Year or Dates:	.S. 13. Was Decedent If Yes, specify 1 ☐ Yes 2X	t of Hispanic Origin? (Sp Cuban, Mexican, Puerto ] No Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify: Wh	e, etc.
15-0	"natur	Completed	15. Decedent's Educ (Specify only highest grade	completed)	16a. Decedent's Usual C (Give kind of work of life. DO NOT use r	occupation done during most of work retired)	ing 16b.	Kind of Business/	Industry
1272 1272	iled with Hygiene. ther that nt, the	Com	Elementary/Secondary (0·12)  17. Father's Name (First, Middle, Last)	College (1-4or 5+)	Home	emaker	e (First, Middle, Maide	Home	
y and	ges 1 and 2 should be filed within to fileath and Mental Hygiene. If item 27 is marked other than or other treumatic event, the Me	To Be	Charles David Tho	_		Joseph	ine Dickso	on	
Man and a second	and 2 sh alth and 127 is m or troum		19a. Informant's Name/Relationship (Typ Raymond G. Keener/		19b. Mailing Address (Si		al Route Number, City .llersville		
EX more	ages 1 and of He nt: If item		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☑ Re 4 ☐ Donation 5 ☐ Other (Specify)	sinoyai nojn State	Place of Disposition (Name of the semetery, crematory or othe enwood Mem.	Dowle Colo	ber 23	Location - City or ver Burre	
Baltimore	permit. Pages Department of Important: ff it any injury or o		21. 5 mature of 5 meral Service Litense	from the	22. Name and A	Address of Facility  8 Sons, P.  Ritchie Hw	A. Severr		uneral Home
			23b Part1. Ener the disease, or complice shock, or heart failure. List only one	/ 11	h. Do not enter the mode o				Approximate Interval Between Onset and Death
	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	Dug to (or as a consequ					
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequence)		tion Pneu	monia		
ć	be executed icien and burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequ	United of):	27			
58760,		edicai	C d.	5 <del>1</del>					
Division of Vital Records, P.O. Box 687	To the Hospital or Attending Physicien: The law requires that the death certificate within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending phys completely filled in by the funeral director, page 2 should be deteched for use as the	Completed by Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	3c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of do 9 ☐ Unknown	I death 3 Ectopic pregr			23d. Date of del Month	ivery Day Year
S.	ires that signed b	by Pr	Part II. Other significant conditions conf	inbuting to death but not resi	ulting in the underlying caus	se given in Part I.	23e. Did tobacco		the cause of death?
Record	he law requ e has been ige 2 should	mpleted	MERODOUC ! CAD		E C II	No contraction of the contractio	24a. Was an autopsy performed?	24b. Were au prior to death?	itopsy findings available completion of cause of
ital	sien: T	Be Co	25. Was case referred to medical exampler?			26. Place of Deat	1 ☐ Yes 2 ☑ Th h (Check only one)	√o 1 □ Yes	212 No
of \	Physic r this co	ပ	1 ☑Yes 2 ☐ No Ho  27. Manner of Death	ospital: 1 Inpatient 2 Inpatient 2 Inpatient 2 Inpatient 2 Input (Month, Day Year)	ER/Outpatient 3 □ DOA 28b. Time of 28c.		me 5 Residence		cify)
sion	tending death. tor: Afte the fune	cation	1		М	1 ☐ Yes 2 ☐ No	OOL Learning (Oter-	- (1)	
Divi	Ital or Al	Certification:	4 Homicide determined	building, etc. (Specify	ome, farm, street, factory, of	пісе	28f. Location (Street City or Town, Sta	ite)	rai Houte Number,
	n 24 hou n 24 hou ne Funei	Medical	29a. Certifier 1 ✓ Certifying Physical (Check only one) 2 ☐ Medical Examin	ician: To the best of my kno er: On the basis of examina and manner stated.	wledge, death occurred at t tion and/or investigation, in	the time, date and place, my opinion, death occur	and due to the cause red at the time, date a	(s) and manner as nd place, and due	stated. to the cause(s)
	To the To the Comp	×	29b. Signature and title of certifler	no HE		1003274	29d. C	Date signed (Monti	n, Day, Year) 2006
	12	1 2	30. Name and address of per who cor Maria Gaviria A	mpleted cause of death (Item 4D 301 H	- 11.00	- Glen Bri	rie MO	2101	61
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Signa	atur*	6			
DH	IMH 17 Rev 1/20	001		SALE OF THE PARTY	The same				

ORIGINAL

		For Stete Registrar	State of Mary	land / Dep		leaith and M	ental Hygie	ene	06	34890	
		Decedent's Name (First, Middle, La	st)				2. Date of Death	11196	0 0	3. Time of Death	
Physici /Medic		Darlene Marie	October			3:40 A M					
Examin	er	4a. Facility Name (If not institution, given				r Location of Death		4c. County			
le le		Calvert Memorial				Frederick			vert		
Funeral Director			Sex 1 □ M XXF 7. Age (In 4.7	yrs. last birthday Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, ) December	'ear) L7, <b>1</b> 95	9. Birth Cou Ma	olace (State or Foreign ntry) ryland	
P .		Usual Residence of Decedent									
rylar		10a. State 10b. County	10	c. City, Town or L						10d. Inside City Limits	
6 Ma	cto	Maryland Saint Mar	ys	Califor	nia				1 ☐ Yes 2 ☑ No		
or 28	Director	10e. Street and Number			10f. Zip Code		100	. Citizen of	What Cou	ntry?	
23e	al	22409 Lacey's Lan	ne		206	19		USA			
deal	Funeral	11. Marital Status	12. Was Decedent Ever Armed Forces?	r in U.S. 13.	Was Decedent of H	lispanic Origin? (Spe an, Mexican, Puerto	ecify Yes or No-		ce - Ameri ck, White,	can Indian,	
after or Ite	T.	1 ☐ Never Married 2X Married	1 ☐ Yes 2 X No				rticari, otc./		y: Wh:		
urs a	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 🔀 No	Specify:		Specia	y: W11.	LLE	
2 ho	ted	15. Decedent's E	ducation	16a. Deci	edent's Usual Occup	pation	16	b. Kind of E	lusiness/Ir	dustry	
n n	ble	(Specify only highest gr Elementary/Secondary (0-12)	College (1-4or 5+)	life.	e kina of work done DO NOT use retire	during most of worki d)	ng				
with liene	Completed	12	1	Но	memaker			Own H	lome		
be filed within 72 hours after death with the Maryland tal Hygiene. Id other then "neturel", or Items 23e or 28e-1 show event, the Medical Evertil or mast be netitied at		17. Father's Name (First, Middle, Las	")			18. Mother's Name	(First, Middle, Ma	iden Sumai	ne)		
d be antal ced c	o Be	Charles Bertram	llen Sto	ne							
houl d Me mark mark	2	19a. Informant's Name/Relationship		19h Mai	ling Address /Street	and Number or Rura			State 7	Code)	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "neturel", or Items 23e or 28e-f show eny injury or other treumetic event, the Medical Examinating the multiple at once.					1747.4						
tealt		Michael Koehler/	Husband		9 Lacey's		lifornia	, Maryı Oc. Location			
of F		20a. Method of Disposition 1  ☐ Burial 2 ☐ Cremation 3 [	Hemoval nom State		osition (Name of ematory or other pla	Oatob	er 26,		ardt		
Pag ment ent: ury c		`4 ☐ Donation 5 ☐ Other (Special	fy)	Charles Me	emorial Gard	lens 20	06	Mary	1and		
permit. Departr Importe eny inj	1	21. Signature of Funeral Service Lice	nsee // 0°	2	22. Name and Addre	ess of Facility	omal Homo	DΛ			
89 = 8		Muchael	Landen	en	41590 Fenwi	Gardiner Fun ck Street Le	onardtown,	MD 206	5ů		
Physician /Medical		23a. Part1 Enter the disease, or cor shoo or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a	ptic	Shock	ng, such as cardiac (	or respiratory arres	t,		Approximate Interval Between Onset and Death	
Examiner			P	eritor,	ti-c				- 11		
	-	Sequentially list conditions, if any leading to immediate	b. Due to (or as a co	17 12							
ted	Examiner	Sequentially list conditions, if any, leading to immediate cauch. Enter those or injury that initiated events	<	evere	Mala	utition	3				
and and	xar	that initiated events resulting in death) Last	c. Due to (or as a co				,				
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ing p	Medi	IF FEMALE:									
ith ce tend or us	an/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of p 1 ☐ Live birth 2 ☐		□Ectopic pregnanc	y		I I	ate of deliv	ery Day Year	
dea od fo	slci	1 ☐ Yes 2 ☐NO	4☐Pregnant at time 9☐Unknown	e of death 5	Other (specify)			1	orier	Day You	
at the by the tach	Physician/M	9 Unknown									
requires that the death certificate be executed een signed by the attending physician and nould be detached for use as the burial-transit	ру Р	Part II. Other significant conditions	contributing to death but no	ot resulting in the	underlying cause giv	ven in Part I.	23e. Did toba			he cause of death?	
quire n sig							1 🗌 Yes	2 🗆 No	3 🗌 Prol	pably 4 Onknown	
	ompleted						24a. Was an	24b.	Were auto	psy findings available	
The taw ite has b	Ę						autopsy performe		death?	mptetion of cause of	
(U) hab	O		1				1  Yes 28	No	1 🗆 Yes	2∐ No	
yeicien: The faw is certificate has t director, page 2 s	Be	25. Was case referred to medical examiner?	Hospital:		Ott	26. Place of Death					
this ld	2	1 ☐ Yes 2 No	Inpatient		AUT 3 DOW	4   Nuising no	me 5 Residen			(y)	
ding P h. After t	on:	27. Manner of Death  ↓ Natural 5 □ Pending	28a. Date of Injury (Month, Day Ye	28b. Time aar) Injury	Wo	rk?	28d. Describe how	injury occur	red		
Attending r death. ector: After	Certification:	2 Accident investigation			M 1	Yes 2 □ No					
	tiffic	3 Suicide 6 Could not determined		- At home, farm, s	treet, factory, office		28f. Location (Stre City or Town,		ber or Run	al Route Number,	
s aft.	Ser	_		//		1	,				
To the Hospitel or within 24 hours after To the Funerel Dir completely filled in	Medical C		hysicien: To the best of m miner: On the basis of exa and manner stated	amination and/or i							
To the within 2 To the comple	Me	29b. Signature and title of certifier	111		29c. Licens	se number	290	I. Date signe	ed (Month,	Day, Year)	
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1015			V'U			22162		10 (	C. Or		
1		30. Name and address of person who		n (Item 23a) (Type	9, Print) 1 1 ∩	Hospital	Road Sud	te 310	Prin	ce Frederick, 0678	
		Johnathan Lowe		Cianat	110	HOSPICAL			MD 2	0678	
Sta Regist	ate	31. Date filed (Month, Day, Year)  OCT 2 3	2006 32. Digistrar's		head ,						

DHMH 17 Rev 1/2001

		Decedent's Name (First, Middle	, Last)							2. Date of I	Da	ıy	Year	3. Time of	Death
Physic /Medi		Adell	F.		Kab:	in				Octobe	r 22	, 20	06	8:30	AM <sup>M</sup>
Exami		4a. Facility Name (If not institution,	_					Location of			40		y of Death	,	
	Щ	St. Mary's Nur	sing Cen	+	rs. last birthday			town		8 Date of I	Righ		Mary		e Foreign
uneral irector		5. Social Security 173 r 166-07-7133  Usual Residence of Decedent	1□M 2X1F	91	Yrs.		Days	Hours	Min.	8. Date of I (Month, March	Day Year	1915	Penn	place (State ontry) 15ylvar	nia
M H		10a. State 10b. County		10c.	City, Town or L	ocation.							1	10d. Inside C	ty Limits
fled	tor	Maryland St.	Mary's		Lexin	gton P	ark							1 🗌 Yes	2X No
000	Funeral Director	10e. Street and Number Weatherby		1,,,,,,,		10f. Zip	Code				10g. C	tizen of	What Cour	ntry?	
event, the Nedical Examiner must be notified at	al	21653 Weatherly					2065					US			
1	ruel	11. Marital Status	Armed	ecedent Ever in Forces?	n U.S. 13.	Was Decede If Yes, speci	ent of His	spanic Ori n, Mexican	gin? (Sp 1, Puerto	ecify Yes or Rican, etc.)	No-		ce - Americ ck, White,		
Bull	by Fu	1 ☐ Never Married 2 ☐ Marri 3 🛣 Widowed 4 ☐ Divorced	ied 1 Tyes If Yes, 0 Year or			1□Yes 2	X No	Specify:				Specif	<sup>ty:</sup> Wh∃	ite	
al Ex	ed t	15. Decedent		Dates.	16a Deci	edent's Usua	i Occupa	ation			16b.	(ind of B	Business/In		
	Completed	(Specify only highes	st grade completed		/Giv	e kind of work DO NOT use	k done d	u <i>rina</i> mos	t of work	ing				,	
	E O	Elementary/Secondary (0-12)  10 th	College	(1-4or 5+)	Hom	emaker	•				Н	ome			
vent,	BeC	17. Father's Name (First, Middle, I	Last)					18. Mothe	er's Nam	e (First, Midd	lle, Maide	n Sumai	тө)		
	ToE	Sylvan Fra	ınkel					R	acha	el Ro	senz	veig			
other traumatic		19a. Informant's Name/Relationsh	hip (Type, Print)		19b. Mai	ling Address	her b	nd Numbe	er or Rui	al Route Nur	nber, City	or Town	, State, Zip	Code)	
		Ronald E. Kabin	1	(son)	the state of the s	3 Weat		-		-	_			20653	3
		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation	3 Removal from		b. Place of Disp cemetery, cre			θ)		Date			- City or To		
5		4 □Donation 5 □ Other (Sp	pecify)	Mo	ontefio					5-2006					
eny inj		21. Signature of Funeral Se Edward N. Br	insfield	Jr M00	0052		Box	279,	, Le	onardt	own,			-	Α.
MP.		23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final	complications that only one cause or	it caused the din each line.	leath. Do not er	nter the mode	e of dying	g, such as	cardiac	or respirator	arrest,			Approximation of the Approxima	ween
ician dical		disease or condition resulting in death)	a	KEL	DUDIES	11-11								NU	1
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ely filled in by the funeral director, page 2 should be detached for use as the	Certification: To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown	b. Dine I  c. Due I  d.   23c. If yes,  1   Livi 4   Pre 9   Uni  pons contributing to  Hospital: 1  Hospital: 1  28a. Da  (M)  gation not be 28e. Plate but  ng Physician: To  Examiner: On the	to (or as a con  outcome of pree birth 2   F ggnant at time known  o death but not  linpatient to of Injury onth, Day Yea  ace of Injury a basis of exar	egnancy Fetal death 3 of death 5  resulting in the  2 ER/Outpatie r) 28b. Time Injury  At home, tarm, s secify)	underlying ca	ause give  ause give  OA Other  Sec. Injury  Work  1 0  7, office	26. Place ar: 4 Nu vat vat v? Yes 2	e of Dea	24a. Wate and the control of the con	Yes 2  as an atopsy informed?  s 2 N  (y one)  asidence be how injunction (Street a Town, State the cause)	use con 2 No 2 4b. 0 Column occu	onth  artribute to t  arrivation of the control of	Day  the cause of (bably 4   popsy findings  pompletion of (2 No  No  All Route Nun  stated.	death?  Unknown  available ause of
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Fulfield in by the funeral director, page 2 should be detached for use as the	edical Certification: To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2  No 9  Unknown  Part II. Dther significant condition  25. Was case referred to medical examiner? 1  Yes 2  No 27. Manner of Death 1  Natural 5  Pendin investig and investigation and investigati	b. Dine I  c. Due I  d.   23c. If yes, 1   Liv 4   Pre 9   Uni  ons contributing to  Hospital: 1   1   28a. Qa (M)  gation not be gation on the building Physician: To Examiner: On the and m	to (or as a con poutcome of pree birth 2   fragnant at time known or death but not present the of Injury onth, Day Yea ace of Injury on the best of my a basis of exaranner stated.	egnancy Fetal death 3 of death 5 resulting in the  Parameter of the second of the seco	ent 3 DO of M street, factory ath occurred a investigation,	ause give  ause give  Oh Othe  Bc. Injury  Work  I ''  /, office  at the tim, in my op	26. Place ar: 4 Nt. y at y? Yes 2 —	e of Dea	24a. Wate and the control of the con	Yes 2  as an antopsy and antopsy antopsy and antopsy and antopsy and antopsy and antopsy and antopsy and antopsy and antopsy and antopsy and antopsy and antopsy antopsy and antopsy and antopsy and antopsy and antopsy and antopsy and antopsy and antopsy and antopsy and antopsy and antopsy antopsy and antopsy and antopsy antopsy and antopsy antopsy and antopsy antopsy and antopsy antopsy and antopsy antopsy and antopsy antopsy antopsy and antopsy antopsy antopsy antopsy and antopsy antop	use con  2 No  24b.  6 Ot  uny occu  and Num  e)  s) and mad place.	were autoprior to codeath?  The red  Th	bably 4 □  popsy findings  pop	death?  Unknown  available ause of
ector: After this certificate has been signed by the attending phy by the funeral director, page 2 should be detached for use as th	edical Certification: To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2  No 9 Unknown  Part II. Dther significant condition  25. Was case referred to medical examiner? 1  Yes 2  No  27. Manner of Death 1  Natural 5  Pendin investig 2  Accident 3  Suicide 6  Could in determine (Chack only one)  29a. Certifier 1  Certifyin 2  Medical one)	b. Dins I  c. Due I  d.   23c. If yes,   1   Livi  4   Pre  9   Uni  ons contributing to  Hospital:   (M  gation not be  lined 28a. Pla  bu  ng Physician: To  Examiner: On the  and m  who come end or	to (or as a con poutcome of pree birth 2   fragnant at time known or death but not present the of Injury onth, Day Yea ace of Injury on the best of my a basis of exaranner stated.	egnancy Fetal death 3 of death 5  resulting in the  2 ER/Outpating 28b. Time Injury At home, tarm, s ecify)  knowledge, deannation and/or ( (Item 23a) (Type)	ent 3 DO of M street, factory ath occurred a investigation,	ause give  ause give  Othe  Bc. Injury  Work  I ''  /, office  at the tim, in my op	26. Place ar: 4 Nt. y at y? Yes 2 —	e of Dea	24a. Wate and the control of the con	Yes 2  as an antopsy and antopsy antopsy and antopsy and antopsy and antopsy and antopsy and antopsy and antopsy and antopsy and antopsy and antopsy and antopsy antopsy and antopsy and antopsy and antopsy and antopsy and antopsy and antopsy and antopsy and antopsy and antopsy and antopsy antopsy and antopsy and antopsy antopsy and antopsy antopsy and antopsy antopsy and antopsy antopsy and antopsy antopsy and antopsy antopsy antopsy and antopsy antopsy antopsy antopsy and antopsy antop	use con  2 No  24b.  6 Ot  uny occu  and Num  e)  s) and mad place.	were autoprior to codeath?  The red  Th	bably 4 bably 4 copsy findings completion of 6 2 No fy)	death?  Unknown  available ause of

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ORIGINAL

Keller

Yrs.

10c. City, Town or Location

7. Age (In vrs. last birthday)

76

Certificate of Death

Months Days

4b. City. Town, or Location of Death

Gaithersburg

If Under 1 Year | If Under 24 Hrs.

Hours

Min

with the Maryland r than "natural", or items 23a or 28s-f show the Medical Examinar must be notified at D.C. None Director Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2500 Wisconsin Ave., N.W. #933 20007 Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Amed Forces?

12 Yes 2 No 1959
If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1X Never Married 2 Married 3altimore, Maryland 21215-0036 1 Yes 2 No δ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 16b. Kind of Business/Industry during most of working Elementary/Secondary (0-12) College (1-4or 5+) Architect Vlastimil Koubek s 1 and 2 should be filed of thealth and Mental Hygie Item 27 is marked other other toumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Cornelius J. Keller Anna Costinett 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) t if item 27 i 2151 Jamieson Ave. #610 Alexandria, VA 22314 Cornelia K. Hudson/Sister 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Oct. Daio7. Pages 5 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If any injury or one 2006 Metropolitan Crematory 4 ☐ Donation 5 ☐ Other (Specify) Alex., Virginia 22. Name and Address of Facility DeVol Funeral Home 21. Signature of Funera Service Lipense 2222 Wisconsin Ave., N.W. Wash., D.C. 20007 MUW 9 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner Aspiration Pneumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed physicien and s the burial-transit Acute Renal Failure Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical Urinary Tract Infection as ed by the attending detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed 24a. Was an has autopsy perform rmed? 2 No 1 ☐ Yes To the Hospitel or Attending Physician: : After this certification : After this certification. Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 📉 No 1 XInpatient 2 ER/Outpatient 3 DOA 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28d. Describe how injury occurred 1 XNatural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident efter death 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours 6 To the Funeral 6 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

34892

3. Time of Death

РМ

8:14

Birthplace (State or Foreign Country)

10d. Inside City Limits

Approximate Interval Between Onset and Death

1 XYes 2 No

New York

White

2006

4c. County of Death

U.S.A.

Specify.

23d. Date of delivery

29d. Date signed (Month, Day, Year)

October 15, 2006

Day

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No

Year

Month

14. Race - American Indian, Black, White, etc.

Montgomery

Rag. No.

8. Date of Birth (Month, Day, Year) July 28, 1930

2 Date of Death

Month Oct.

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State

Registrar

10

29b. Signature and title of certifier

Petek Donmez 31. Date filed (Month, Day, Year)

**NCT** 

Jannez

2006

18

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

WD

Registrar's Signature

8910 Medical Drive Gaithersburg, MD

1 - For State Registrar

10a State

**Physician** 

/Medical

Examiner

**Funeral** 

Director

1. Decedent's Name (First, Middle, Last)

Shady Grove Hospital

10h County

4a. Facility Name (If not institution, give street and number)

1X M 2 T F

Michael

5. Social Security Number

Usual Residence of Decedent

578-38-4837

29c. License number

D62999

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			1 - State Registrar Certificate of Death Reg. No.							09000		
	Dharini		1. Decedent's Name (First, Middle, Last)					2. Date of Deat Month	th Day Yea	3. Time of Death		
	Physici /Medio		William Frederick	Keyes, Sr.				October	18 2000	10:18 PM		
	Examir	ier	4a. Facility Name (If not institution, give Washington County			Hager		4c. County of Death Washington				
	Funeral Director		212 24 3103	7. Age (In yrs. last	st birthday) Yrs.	Months Days		8. Date of Birth (Month, Day, 01/19/1	9. B 933	irthplace (State or Foreign Country)  MD		
	iand		Usual Residence of Decedent  10a. State  10b. County	10c. City,	Town or Lo	cation				10d. Inside City Limits		
	Many Ind	tor	MD Washing	ton	Hage	erstown				1 X Yes 2 □ No		
	death with the Maryland ms 23a or 28a-f show ringst be notified at	I Director	10e. Street and Number 154 W. North Aven	ue		10f. Zip Code 217	40	1	10g. Citizen of What Country? US			
0030	or Ita	by Funeral	11. Marital Status  1 ☐ Never Married 2 ☒ Married  3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates:	11	Vas Decedent of h Yes, specify Cub	Hispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ar Black, Wh Specify:	nerican Indian, nite, etc. Black		
ဂ ဂ	72 ho	eted	15. Decedent's Edu		16a. Deced	lent's Usual Occup	pation during most of work	ina	16b. Kind of Busines	s/Industry		
7	e filed within 72 hours il Hygiene. other than "neturel", vent, the Medical Exe	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life. L	oo not use retire aterial	d)		Auto	motive		
<u> </u>	ould be filed Mental Hygi arkad other atic event, I	To Be Co	17. Father's Name (First, Middle, Last)  Reginald O. A. Keves, Sr.  18. Mother's Name (First, Middle, Last)  Cecelia						Maiden Sumame) Stoner			
, mary	S DE E		19a. Informant's Name/Relationship (Type, Print)  Jacqueline Y. Keyes / Wife  19b. Mailing Address (Street and Number or Rural Route Number, City or To									
ore	ges 1 st of He if itam		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ R	emoval from State	netery, crem	sition (Name of natory or other pla	сө)		20c. Location - City			
Saltimor	t. Pag rtment rtsnt: rjury		4 ☐Donation 5 ☐ Other (Specify)	Ceda			3dn. 10/23		Hagerstow			
pa	permit. Pages 1 and 2 Department of Health s Importsnt: If Itam 27 li any Injury or other tra		21. Signature of Funeral Service License						Minnich F erstown,	uneral Home MD 21740		
ı			23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final	ications that caused the death.	Do not ente	er the mode of dyn	ng, such as cardiac	or respiratory arre	est,	Approximate Interval Between Onset and Death		
	Physician /Medical		disease or condition resulting in death)	Due to (or as a conseque	nce of):	2 your	5584 14	1	chroma			
	Examiner		Sequentially list conditions,	Scupe		Bprzto.	1y dus	trest				
٦	ed sit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseque	ence of):	V	/					
•	icate be executed physician and s the burial-transit	хап	that initiated events resulting in death) Last	Due to (or as a conseque	nce of):							
00/00	ysiciar ysiciar		L,	d								
0	ertifica ling ph e as th	Medical	IF FEMALE:									
. ao	ettend for us	Physician/I	23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregnand 1 ☐ Live birth 2 ☐ Fetal d 4 ☐ Pregnant at time of dea 9 ☐ Unknown	leath 3	Ectopic pregnanc Other (specify)	у		23d. Date of d Month	elivery Day Year		
cords, r.	w requires that the de been signed by the should be detached	þ	Part II. Other significant conditions con	ntributing to death but not result	ing in the ur	nderlying cause giv	ven in Part I.	23e. Did tob	23e. Did tobacco use contribute to the cause of death?  1 les 2   No 3   Probably 4   Unknown			
Neco	a 2 C	ompieted						24a. Was ar autops perform	ned? death	autopsy findings available o completion of cause of		
\   [a	slan: artifice ctor, p	BeC	25. Was case referred to medical examiner?				26. Place of Deat					
5	this co	ဥ	1 Yes 2 No		R/Outpatien	30,000			nce 6 Other (Sp	pecify)		
DIVISION	sending Physician: The leath. or: After this certificate ha the funeral director, page	Certification:	27. Manner Death  1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day Year)	8b. Time of Injury	M 1 □	Yes 2 □No		w injury occurred			
	ital or At irs after d rst Dirscl led in by	Certifi	4 Homicide determined	28e. Place of Injury - At hom building, etc. (Specify)				City or Town				
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifior completely filled in by the funeral director,	Medical	29a. Certifying Physics (Check only one)	sician: To the best of my knowl ner: On the basis of examinatio and manner stated.	edge, death on and/or inv	estigation, in my o	opinion, death occur	and due to the ca red at the time, da	ause(s) and manner ate and place, and d	as stated, ue to the cause(s)		
	With To I	Z	29b. Signature and title of certifier	1, un. E	,	29c. Licens	04113		9d. Date signed (Mo.			
H-	9+1		30. Name and address of person who co		23a) (Type, I	Print) (15)	us Ope	il Con.	the o	1740		
3	Sta Registi		31. Date filed (Month, Day, Year) OCT 2 3 20									
_					6 3							

	٨		1 - For State Registrar	State of Ma			ment of F ficate of			leg. No.	006	34894	
	Physici		Decedent's Name (First, Middle, La.  Margar		Lan	ghenr	У		2. Date of Dea		2006	3. Time of Death 7:05 AMa	
8-	°/Medic Examin		4a. Facility Name (If not institution, given Glade Valley Nursing		itation C	4b. City, Town, or Location of Death 4c. Co						:k	
	Funeral Director		5. Social Security Number 6. S 577-03-4886	ex 7. Age	(In yrs. last bin	thday) If	Under 1 Year onths Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day June 12	2, 191	9. Birth Cou Was	olace (State or Foreign ntry) shington, DC	
	Maryland -f show	tor	Usuel Residence of Decedent  10a. State 10b. County  Maryland Frederi	ck	10c. City, Town			<u> </u>				10d. Inside City Limits 1 □XYes 2 □ No	
	th with the 23e or 28e	al Director	10e. Street and Number 56 Frederick	Street			10f. Zip Code 21793			10g. Citizen	ntry?		
900	n 72 hours after death with the Maryland "naturs!", or itsms 23e or 28e-f show ledical Examinar must be notified at	by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12, Was Decedent 8 Armed Forces? 1  Yes 2 No 1f Yes, Give Year or Dates:	? If Yes, specify Cuban, Mexican, Puerto No 1 □ Yes 2X No Specify:			ecify Yes or No- Rican, etc.)		Race - Americ Black, White, ecify: Whi			
Maryland 21215-0036	C _ 9	Completed	15. Decedent's Ed (Specify only highest grade) Elementary/Secondary (0-12)			Decedent (Give kind life. DO	's Usual Occup d of work done NOT use retired	ation during most of work d)	ang	16b. Kind o	of Business/In	dustry	
121	be filed withintal Hygiene. Id other than svant, the M		12		C	lerk/	Account	ting Depa		ment Insurance Company  First, Middle, Maiden Surname)			
ylan	should be nd Mental I marksd o umatic svs	To Be	Jesse Thomas						e Gertru				
Mar	nd 2 lith a 27 is r tra		19a. Informant's Name/Relationship ( Mrs. Valorie J.	**				and Number or Rur Hills Dr					
Baltimore,	m O		20a. Method of Disposition 1			y, cremato	ory or other place	etery Oct	Date . 28, 20		ion - City or To Brentwo		
Balt	permit. Page Department of Important: If any injury of once.		21. Signature of Funeral Service Licer	<b>U</b> 1	00255	22. Na Kee	eney and Addre	s of Facility I Basford Church St	PA Fune	eral H	Tome	701	
	Physician		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition		the death. Do r	not enter th	ne mode of dyin	ig, such as cardiac	or respiratory arr	est,		Approximate Interval Between Onset and Death	
8,09289	Medicate be executed Examine by strict and street as the burial-transit	dical Examiner	edical Examiner	resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that intitated events resulting in death) Last	b. Due to (or as a	a consequence of a consequence of a consequence of	ER	TBNS	700				20 years
P.O. Box 6	ath cer	Completed by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcome of 1 Live birth 4 Pregnant at 9 Unknown	2 Fetel death		opic pregnancy her (specify)			23d.	Date of delive Month	ery Day Year	
	v requires that the de been signed by the a should be detached t	ted by Pł	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23e. Did tobacco use contribute to the cause of death?  1  Yes 2 No 3 Probably 4 Unknown			
Division of Vital Records,						-			24a. Was a autops perform	sy med? 2⊠No	4b. Were auto prior to co death? 1 \(\sum \) Yes	psy findings available mpletion of cause of 2 No	
Z.	Physician: r this certific ral director,	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatie	nt 2 🗆 ER/Ou	tpatient 3	B□ DOA Oth	26. Place of Deat er: 4 ☑ Nursing Ho	h <i>(Check only or</i> ome 5□ Resid		Other (Specif	v)	
sion of	ing Afte une	Certification: 1	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injur (Month, Day	y 28b. T	ime of	28c. Injun Wor		28d. Describe h				
Divi	al or Attand s efter death al Director: /	Sertific	3 Suicide 4 Homicide  6 Could not be determined  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)							treet and Nu n, State)	umber or Rura	il Route Number,	
	s Hospital or 1 124 hours efter • Funerel Dire letely filled in b	edical	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exert	ysicien: To the best on niner: On the basis of and manner sta	examination and	dor invest	curred at the tin igation, in my o	ne, date and place, pinion, death occur	and due to the c red at the time, d	ause(s) and ate and place	d manner as s ce, and due to	tated. the cause(s)	
	To the within 2 To the complete	Me	29b. Signature and title of certifier	Hi	- M.D.		29c. Licenso	1944 1944	2		gned (Month, ober 23		
	<b>\</b>		30. Name and address of person who		eath (Item 23a) (	Type, Prin	"TAN	6Y #20L	FRED	BRICK	C,Mb	, 21702	
	Sta Registr		31. Date filed (Month, Day, Year) NOV 0 2 200		r's Signature	press	20						
					-								

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			For State Registrar	State of Maryland		rtment of H			giene 00	6 34895
18	Physici		1. Decedent's Name (First, Middle, Last)	L	ee			2. Date of Dea Month	th Day Ye	3. Time of Death
	/Medio		4a. Facility Name (If not institution, give s	(3)		4b. City, Town, or	Location of Deat		4c. County of E	Death
	Funeral Director		5. Social Security Number 6. Sex 10 10 10 10 10 10 10 10 10 10 10 10 10			If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		y, Year) 9.	Birthplace (State or Foreign Country) irginia
	Maryland -f show	tor	Usual Residence of Decedent  10a. State 10b. County  Maryland Anne Ar		, Town or Loc	ation				10d. Inside City Limits 1 ☐ Yes 2 🛣 No
	with the	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of Wha	t Country?
21215-0036	be filed within 72 hours after death with the Maryland ital Hygiene. Id other than "natural", or items 23e or 28e-f show event, I'le Medical Elacting rulel to rotified at	y Funeral	1 Never Married 2 Married	12. Was Decedent Ever in U.S Armed Forces? 1	If	21012 as Decedent of Hi Yes, specify Cuba  Yes 27 No	spanic Origin? (S	Specify Yes or No- to Rican, etc.)		tates American Indian, White, etc.  White
	nin 72 hours in "natural", Medical Exe	Completed by	3 X Widowed 4 □ Divorced  15. Decedent's Edu (Specify only highest grade) Elementary/Secondary (0·12)	Yeer or Detes:	16a. Decede	ent's Usual Occupa ind of work done of O NOT use retired	ation during most of wo	rking	16b. Kind of Busine	
	e filed within al Hygiene. I other than '			4		Homema		man (Final Middle	Own H	ome
lanc	should be find Mental Finarked of	To Be	17. Father's Name (First, Middle, Last) Alvin Lee Smith				Manie	me <i>(First, Middl</i> e, Cox	Maiden Sumame)	
, Maryland	nd 2 shuith and 27 is m		19a. Informant's Name/Relationship ( <i>Ty</i> , Mary Ruck / Daugh						r, City or Town, Sta.	te. Zip Code) d , MD 21012
Baltimore,			20a. Mathod of Disposition 1-☑Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	rna U/N	atory or other place 1 Cemete	ery 10/			, Virginia
Balt	permit. Pa Departmen Important any injury once.		21. Signature of Funeral Service License	ll_	14	47 Duke o	of Glouc	ester St.	. Annapol:	eral Home,Inc. is, MD 21401
8760,	Physician buyarician and physician and physician and street is the partial transit	al Examiner	23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	e cause on each line.	A R pence of):	De Me		c or respiratory arr	est,	Approximate Interval Between Onset and Death
P.O. Box 687	death certifi e attending ed for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown	3c. If yes, outcome of pregnar 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown	death 3□E	Ectopic pregnancy Other (specify)			23d. Date of Month	delivery Day Year
Ś	w requires that the been signed by the should be detache	by	Part II. Other significant conditions con		Iting in the und	derlying cause give	on in Part I.	23e. Did to		te to the cause of death?  Probably 4 Unknown
al Record	The taw ate has b page 2 s	Completed						24a. Was a autops perform	meda prior deat	e autopsy findings available to completion of cause of h? Yes 2 \(\sumbolear\) No
Vital	Physician: The tribis certificate har all director, page	o Be	25. Was case referred to medical examiner?  1 Yes 2 No	ospital: 1 ☐ Inpatient 2 ☐ E	ER/Outpatient	3□ DOA Othe	r /	ath Check only on	ence 6 Other (5	Canada
ion of	ding Ph h. After th funeral	$\vdash$	27. Manner Death  1 Natural 5 Pending  2 Accident investigation		28b. Time of Injury	28c. Injury Work			ow injury occurred	<u></u>
Division		Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At hos building, etc. (Specify,	) 			City or Town	n, State)	r Rural Route Number,
	To the Hospitel o within 24 hours aft To the Funerei D completely filled in	edical	29a. Certifier 1 Certifying Physical Check only one) 1 Medical Examination	sician: To the best of my knowner: On the basis of examination and manner stated.	vledge, death of ion and/or inve	occurred at the time estigation, in my op	e, date and place inion, death occu	e, and due to the curred at the time, d	ause(s) and manne ate and place, and	r as stated. due to the cause(s)
	To th withir To th compl	Me	29b. Signature and title of certifier	A. Sh.	h m	29c. License	number (6361)	) (	9d. Date signed (M	Inth, Day, Year)
•	2		30. Name and odress of person who co	mpleted cause of death (Item	23a) (Type, P	rint) 8/1/1 11	0-0-0-	Med	nA.	110
7	Sta	20.00	31. Dat Filed (Month, Day, Year)  OCT 1 8 20	32 Pegistrar's Signat	ure A		KI CHIVS	ITEHNAS	reflue	17, 2006 1851140 MD 21108

			For State Registrar	State of N	Maryland		artment of			lental Hygie	ene 0 0 (	6	34896
	Physici	an	1. Decedent's Name (First, Midd	e, Last)	pert Marcellus Llewellyn							ear	3. Time of Death
	/Media	al	4a. Facility Name (If not institution	4h City Town	n, or Location of	October	26, 2006 4c. County of	Death	10:07 A. M				
	Examin	er	, ,	Buskirk Hollow	•	W	35. Oky, 10m		rostbu	ırg	•	Allega	anv
	Funeral		5. Social Security Number		ge (In yrs. I	ast birthday)	If Under 1 Ye Months Dar	ar If Under		8. Date of Birth (Month, Day, Y			ace (State or Foreign
	Director		219-34-6278 Usual Residence of Decedent	1201	72	Yrs.				October 12,		M	aryland
	yland how		10a. State 10b. County		10c. City	, Town or Lo	ocation	-				10	d. Inside City Limits
	Ba-f e	Director		Allegany				Frostbu	ırg				1 ☐ Yes 2 XNo
	with the	Dire	10e. Street and Number	dala II. II. aa Daa	LOW		10f. Zip Cod			100	g. Citizen of Wha		
	death me 23	Funeral	11. Marital Status	tirk Hollow Road	t Ever in U.S	S. 13.	Was Decedent	21532 of Hispanic Ori		ecify Yes or No- Rican, etc.)	14. Race -	J.S.A. America	
9	or its	y Fui	1 Never Married 2 Mar	If Yes Give	No		ir Yes, specify C 1 ☐ Yes 2 🛣 n		i, Puerto i	Hican, etc.)	Specify:	White, et	tc.
Ö	n 72 hours neturel,	ed by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates	:		dent's Usual Oc			10			White
215	hin 72	plet	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)			(Give	kind of work do DO NOT use ret	ne during mosi ired)	t of workir	ng	b. Kind of Busir	iessyinal	istry
21	be filed within 72 hours after death with the Maryland the Hygiene. A thygiene dither then "neturel" or iteme 23s or 28s-f ehow event, the Madical Examinar must be motified at	Be Completed	12	0	34)			Machinis	t			Paper	•
and			17. Father's Name (First, Middle,	Marcellus Llewe	alla m			18. Mothe	r's Name	(First, Middle, Ma			
چ	2 should be and Mental is marked raumatic eve	ပ	19a. Informant's Name/Relations		anyn	19b. Mailir	ng Address (Stre	et and Numbe	r or Rura	I Route Number, (	ie Cutter	ite. Zip C	Code)
Ž.			Paddy Margaret	Llewellyn - Wife	e					Road, SW,	-	-	
Baltimore, Maryland 21215-0036	of He		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation	3 ☐Removal from Stat		metery, crer	sition (Name of natory or other p	olace)		ate 20 tober 29,	c. Location - Cit	y or Tow	n, State
E	permit. Pag Department Important: i eny injury o once.		4 □ Donation 5 □ Other (S	Specify)			land Crem				umberland,	Mary	land, 21502
Ba	Depa Impo eny i		Jes C Mul	7/		22		Eichhor	n-McI	Kenzie Fune			
			23a. Part1. Enter the disease of shock, or heart failure. List	complications that cause only one cause on each	ed the death line.	. Do not ent	er the mode of o	tying, such as	ain Str cardiac oi	eet, Lonacor r respiratory arres	ning, MD 2	1	Approximate nterval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)	_a Metas	statio	e the	05TA 7	TE C	ANC	ER			Onset and Death Year 5
	/Medical Examiner		resulting in dealtr)	Due to (or a	s a consequ	ence of):							t
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or a	s a consequ	ence of):					-		
	and and transi	Examiner	that initiated events C.										
8760,	ate be executed hysicien and the burial-transit	al E	rosaling in dozuly East	Due to (or a	s a consequ	ence of);							
289	g phys g phys as the	edical		d									
Rox	eath certific attending p for use as	an/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom 1 ☐ Live birth			]Ectopic pregna	ncv			23d. Date of	-	
o D	The law requires that the death certificate be executed its hes been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant 9□Unknown	at time of de		Other (specify)				Month	D	ay Year
a.	s that the de ned by the a detached t	by Ph	Part II. Other significant conditi	ons contributing to death	but not resu	lting in the u	nderlying cause	given in Part I.		23e. Did tobac	co use contribu	te to the	cause of death?
Vital Records,	w requires been sign should be	ed b	DM. 54	evere De	nout	an '				1 ☐ Yes	2□No 3[	Probab	oly 4 Donknown
မိုင်	es be	Completed	Hyperl	pedeme						24a. Was an autopsy	Drioi	to come	y findings available detion of cause of
			· /	V						performe	do deat		□ No
5	y sicia s certi directo	o Be	25. Was case referred to medica examiner?  1 ☐ Yes 2 ☑ No	Hospital:	ient 2 🗆 E	R/Outpatien	t 3□ DOA			Check only one	e 6 □Othor (	Casasta	
0	ng Phy fter thi	T:uc	27. Manner of Death 1 Natural 5 Pendir	28a. Date of In	ury	28b. Time of	28c. In	jury at		8d. Describe how		<i>эрөспү)</i>	
DIVISION	ttendi death. tor: A the fu	catl	2 Accident investi	gation not be			M 1	☐ Yes 2 ☐ N		201			,
	effor A setter if Direct d in by	Certification:	4 Homicide determ	building, e	atc. (Specify)	ne, tarm, str	eet, factory, offic	:e	2	8f. Location (Stree City or Town, S	at and Number of State)	r Hurai F	Houte Number,
	To the Hospital or Attending Physician: within 24 hours efter death. To the Funeral Director: After this certifice completely filled in by the funeral director, t	edical (	29a. Certifier 1 Certifyir (Check only one) 2 Medical	g Physician: To the bes Examiner: On the basis and manner s	of examinati	vledge, death on and/or inv	occurred at the restigation, in m	time, date and y opinion, deat	d place, a h occurre	nd due to the caused at the time, date	se(s) and manne and place, and	er as stat	ed. ne cause(s)
	vithin To th compl	Me	29b. Signature and title of certifie				29c. Lice	nse number	11 .	29d	Date signed (N	fonth, Da	ay, Year)
	8		•	organ	ellin	Ma		144	-64	Innd o	10-2	6.	2006
			30. Name and address of person S. L. San chik	the second	death (Item	23a) (Type,	Frint)	in 1	1, 4	1	71000		
	Sta	te	31. Date filed (Month, Day, Year)	32. Regis	trar's Signatu	ure	1 11 105 1 00	9, 11	MY	MINCE O	(1) ~ 2		
	Registr	ar	OCT 2	7 2006	and the		200/1						

			1 - For State Registrar	State of Marylan		artment of tificate o			giene 0	6 34897
1	Physic	ian	Decedent's Name (First, Middle,		£			2. Date of Dea	ath	3. Time of Death
1	/Medi		Sylvia	Lighter	n51	ern		OUT	17 20	06 1545 M
1	Exami	ner	4a. Facility Name (If not institution,	1_1	St	4b. City, Town	1	Death	4c. County of	Death  JOHNERY
E	Funeral		1 - 2 -	3. Sex 7. Age (In yrs.	last birthday)	If Under 1 Yea		4 Hrs. 8. Date of Birt		
н	Director		085-16-8863	1□M 2⊠F 85	2.	Months Day	s Hours	4 Hrs. 8. Date of Birt (Month, Da) Apr. 24	y, Year) ,1921	9. Birthplace (State or Foreign Country) New Yor!<
	pu *		Usual Residence of Decedent  10a. State 10b. County	10a Cii	ty, Town or Lo					
	Meryle	ţ	Maryland Montgon		Garret					10d. Inside City Limits 1   Yes 2   No
	s 1 and 2 should be filled within 72 hours efter deeth with the Maryland if Heelth and Mantel Hygiene. Item 27 Is marked other then "natural", or Items 23a or 28a-f show other traumatic event, the Madical Expandred rust be notified at	al Director	10e. Street and Number 10713 Weymouth	Street		10f. Zip Code	20896		10g. Citizen of Wh United	
9	ofter deer	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Marrie		H			in? (Specify Yes or No- Puerto Rican, etc.)		American Indian, White, etc.
21215-0036	inel', o	d by	3 ☑Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1	☐Yes 2⊠N	o Specify:		Specify:	White
5	72 h "nætu	ete	15. Decedent's (Specify only highest	Education grade completed)	(Give )	ent's Usual Occi	e during most	of working	16b. Kind of Busin	ness/Industry
121	withln Bne. then	Completed	Elementary/Secondary (0-12)	Coflege (1-4or 5+)		OONOT use retii 1 Assis			Dentis	+ rv
	2 should be filed von the standard by the standard other fraumatic event, it		17. Father's Name (First, Middle, La	*		- 135010	,	s Name (First, Middle,		-
Maryland	kad c	To Be	Max Silver					Bernstein		
ary	should and Men marks umatic		19a. Informant's Name/Relationship	(Type, Print)	19b. Mailin	g Address (Stree		or Rural Route Numbe	r, City or Town, Sta	ate, Zip Code)
	end 2 selth e n 27 le		Jeremy E. Lichte	nstein/ Son	11180	Kenilwo	orth Av	e. Garrett	Park, M	20896
altimore,	of He		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3	DRemoval from State G⊇G	Place of Dienos	ition /Nama of	1	Data	20c. Location - Cit	ty or Town, State
Ë	Peges tment of I tent: If It		* 4 ☑ Donation 5 ☐ Other (Spe		ical C	enter	sity O	ctober 17		con, D.C.
Ba	permit. Peges 1 en Depertment of Heel Important: If Item 2 eny Injury or other 2052.		21. Signature of Funeral Service Lie	Jak.	22. P.	O. Box	ress of Facility 58007	Columbia Mo Washington	ortuary S , D.C. 20	Services, Inc.
Н			23a. Part1. Enter the disease, or co shock, or heart failure. List or	implications that caused the death	h. Do not ente	r the mode of dy	ring, such as ca	ardiac or respiratory arr	rest,	Approximate Interval Between
1	Physician		Immediate Cause (Final disease or condition resulting in death)	- Hyperter	91 VP	Caro	40003	culor 4	50050	Onset and Death
1	/Medical Examiner		resulting in death)	Puedo (or as a consequ	uence of):	- A/		,		Dank
		-	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a consequ	uence of):					
	uted	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events							9
o,	exec en an		resulting in death) Last	Due to (or as a consequ	uence of):					
8760,	ste be executed hysicien and the buriel-trensit	dical		d						
9	entifice ling pt	Med	IF FEMALE:			-				
Вох	leeth certific ettending p I for use es	lan/Mec	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregna 1☐Live birth 2☐Fetal	ldeath 3⊡l	Ectopic pregnanc	су		23d. Date o Month	f delivery Day Year
P.O.	lew requires that the death certific es been signed by the ettending p 2 should be deteched for use es	Physici	1 ☐ Yes 2 No 9 ☐ Unknown	4☐Pregnant at time of de 9☐ Unknown	eath 5∐	Other (specify)				July . Jul.
	thet ned by dete	4	Part II. Other significant conditions	contributing to geath but not resi	ulting in the un	derlying cause g	iven in Part I.	23e. Did tol	bacco use contribu	ite to the cause of death?
of Vital Records,	aulres n n signe	d by	AGLOMING	gortic an	PUT	-Sm		1 🗆 Ye	es 2 □No 3[	Probably 4 Unknown
000	lew requir ss been s 2 should	Completed	,		/			24a. Was a	ın 24b. Wer	e autopsy findings available
Ä	음 - 유 - 유 - 유 - 유 - 유 - 유 - 유 - 유 - 유 - 유	E						— autops perforr 1 ☐ Yes 2	med? deat	r to completion of cause of th? Yes 2 No
/ita	sician: 1 certificet rector, p	Be	25. Was case referred to medical examiner?				26. Place o	f Death (Check only on	- 1	103 20110
7	g : 5	၉	1 Yes 2 No	The second secon	ER/Outpatient	JU DOX		ing Home Reside	ence 6 Other (	Specify)
Ž.	fing F	ō.	27. Manner of Death 1 ☐ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Inju			ow injury occurred	
Division	il or Attending after deeth. Director: After	Icat	2 Accident investigat 3 Suicide 6 Could not	be an Bloom of Lairne At he	me farm stre		]Yes 2 □ No		root and Number o	or Rural Route Number.
S	after Dire	Certification;	4 Homicide determine	building, etc. (Specify	<i>')</i>	or, raciory, omco		City or Town		r nural noute Number,
	To the Hospital or Attending Phwithin 24 hours after deeth. To the Funeral Director: After th completely illied in by the funeral		29a. Certifier 1∐ Certifying	Physician: To the best of my know	wledge, death	occurred at the t	ime, date and I	place, and due to the ca	ause(s) and manne	or as stated.
	in 24 he Ft. pletel	Medical	(Eneck only 212) Medical Ex	aminer: On the basis of examinat	tion and/or inve	stigation, in my	opinion, death	occurred at the time, da	ate and place, and	due to the cause(s)
	To the within 2 To the complet	Σ	29b. Signature and title of certifier	a. ()		29c. Licen	se number	25	9d. Date signed (M	lonth, Day, Year)
•	10		b gen 1)	solckerm	Ome	1)0	042	10	Jet 1	7 2006
			30. Name and address of person wh	completed cause of death (Item	23a) (Type, P	rint) 2/0	me	tical Pai	C Dr	0-0
	Sta	te	31. Date filed (Month, Day, Year)	32 Registrar's Signat	ture	JIV!	181 7	11 64 110	لا ما	1902
2	Registr	ar	29b. Signature and title of certifier  30. Name and address of person wh  Self Control of the Co	2006 House B	400	Me de la company				

			For State Registrar	State o	of Maryland		artment of H		Mental Hygie	-2111	6	34898
	**		Decedent's Name (First, Midd	le, Last)	<del></del>				2. Date of Death	j. 140.		3. Time of Death
á	Physici /Medio		WALI	LACE NAT	HANIEL	LOMAX			OCT.		706	11:15 A M
#) 32.	Examir		4a. Facility Name (If not institution	n, give street and nu	mber)		4b. City, Town, o	or Location of Death		4c. County o	Death	
			PRINCE GEORG					VERLY	T =	PRINC		
*	Funeral Director		5. Social Security Number 577–12– 936	6. Sex 1 <b>∑</b> M 2 ☐ F	7. Age (In yrs. las	Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day, Y) FEB. 4,	<sup>(ear)</sup> 1919	Countr	Ice (State or Foreign Y) I. D.C.
	pug *		Usual Residence of Decedent  10a. State 10b. County	,	10c. City	Town or Lo	cation				10	d. Inside City Limits
	Maryli f sho	lor		CE GEORGES			IVERDALE				10.	1½ Yes 2 □ No
	r 28a	Director	10e. Street and Number	JE GEORGED	<u>'                                    </u>		10f. Zip Code		100	J. Citizen of Wh	nat Countr	y?
	th with		4409 EAST V	WEST HWY.			207	37		U.S	Α.	
	r dea	Funerai	11. Marital Status	12. Was Dec Armed Fo	edent Ever in U.S. prces?	13. \	Was Decedent of H	dispanic Origin? (Sp an, Mexican, Puerto	pecify Yes or No-	14. Race Black	America White, et	
36	rs atte	by Fi	1 ☐ Never Married 2 ☐ Mar 3 ※ Widowed 4 ☐ Divorced	If Yes Gi	ve		I□Yes 2¶ No	Specify:		Specify:		
8	within 72 hours atter death with the Maryland ene. than "natural", or Iteme 23s or 28s-f show ha Medicel Examiner must be notified at	ted t	15. Deceder	it's Education		16a. Deced	lent's Usual Occup	pation	16	6b. Kind of Bus	BLAC	
21215-0036	thin 7:	Completed	(Specify only higher Elementary/Secondary (0-12)	st grade completed) College (	1-4or 5+)	(Give lite. L	kind of work done OO NOT use retire	during most of world)	king			•
	ygien ygien t, the	Con	12				DRIVER					C STORE
Maryland	ntai H ed oth	Be	17. Father's Name (First, Middle,	,					e (First, Middle, Ma		)	
Ĭ	thould Mel	မ	JOHN I		MAX	19h Mailin	n Address (Street		BEL ra <i>l Route Number, C</i>	WEAVER	h to Zin C	Codel
	nd 2 sulth ar			NOIT/SIST	ER				TTEVILLE,			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
re,	s 1 a of Hea item othe		20a. Method of Disposition	· · · · · · · · · · · · · · · · · · ·	20b. Pla	ce of Dispo	sition (Name of natory or other pla			c. Location - C		n, State
Ē	Page nent c ant: If	100	1 XBurial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (5		State			CEM. 10-2	0-2006	SUITLAN	ND, M	D.
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours atter death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Iteme 23a or 28a-f show any Injury or other traumatic event, the Medical Examinar must be notified at once.		21. Signature of Funeral Service	Ligerisee	@ M000	91 5	Name and Addre HAMBERS 801 CLEVI	FUNERAL H	OME & CRE	MATORIU ALE. MI	M,Р.	A. 737
			23a. Part1. Enter the disease, o shock, or heart failure. List	complications that of	caused the death						- /	Approximate nterval Between
	Physician :		Immediate Cause (Final disease or condition	Se	ASIS	<						Onset and Death
	/Medical Examiner		resulting in death)	aDue to	(or a conseque	nce of):						1
	- Adminici	-	Sequentially list conditions,	b. Due to	(or as a conseque	ON one	19					Jays
	uted Insit	mine	if any, leading to immediate Cause (Disease or injury	S Due to	(or as a conseque	rice ory.						
o,	s be executed sician and burial-transit	Examin	that initiated events resulting in death) Last	c. Due to	(or as a conseque	nce of):					-	
8760	cate be executed physician and the burial-transit	dicai		d								
9	ertitica ling pt e as ti	Med	IF FEMALE:	1							-	
Box	death certiti e attending id tor use as	ian/	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live t	tcome of pregnand pirth 2 Petal d	eath 3	Ectopic pregnancy	,		23d. Date Monti	,	/ Pay Year
o.	ires that the death certitic signed by the attending f d be detached tor use as	Physician/Me	1 □ Yes 2 □ No 9 □ Unknown	9□ Unkn	nant at time of dea own	tn 5L	Other (specify) _					•
Ω_	The law requires that the tee bas been signed by the base been signed by the bage 2 should be detache	by Pr	Part II. Other significant conditi	ons contributing to d	eath but not resulti	ing in the un	iderlying cause giv	en in Part I.	23e. Did toba	cco use contrib	ute to the	cause of death?
ıds	w require been sig should b		Ronal	Fail	une				1 ☐ Yes	2 □ No 3	Probat	oly 4 Unknown
eco	e law requ has been je 2 shoul	Completed							24a. Was an autopsy	24b. We	re autops	sy findings available pletion of cause of
<u> </u>		Con							performe	d? dea	ath? Yes 2	
Zi ta	ician: Th certificate rector, pag	Be	25. Was case referred to medica examiner?	Hospital:			1 04		h (Check only one)			
ō	ding Physician: h. Atter this certitic tuneral director,	<u>د</u>	1 Yes 2 No 27. Manner of Death	28a. Date		Outpatient  8b. Time of	3 DOA Oth	4 🗀 Nursing no	ome 5 Residence			
on	tth. :: Atter	atlon	1 ☐ Matural 5 ☐ Pendir 2 ☐ Accident investi	ng (Mon	th, Day Year)	Injury	28c. Injur Wor M 1 🗆	k?` Yes 2 □No	200. 2000100 1104	injury occurred	•	
Division of Vital Records,	or Attence after death Director:	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	ined 200. Flace	of Injury - At homing, etc. (Specify)	e, farm, stre	eet, factory, office		28f. Location (Street	et and Number	or Rural I	Poute Number,
	ital or A irs after rai Directed in by								City or Town, S			
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely tilled in by the tuneral director,	Medicai	29a. Certifier  (Check only one)  1 Certifyin  2 Medical	ng Physician: To the Examiner: On the b and man	best of my knowle asis of examination ner stated.	edge, death n and/or inv	occurred at the tirestigation, in my o	ne, date and place, pinion, death occur	and due to the caus red at the time, date	se(s) and mann and place, an	er as stat d due to t	he cause(s)
	To the within 2. To the complet	Ž	29b. Signature and title of certifie	1	, (		29c Licens			. Date signed (		
	2_		Fundle	new	re him	/	DE	11823	- 16	OCTU	ber	200k
			30. Name and address of person	who completed caus	se of death (Item 2	За) (Туре,	Print)	him DI	- 16 Hyatts	- Ellal	MX	70721
200	Sta	te	31. Date filed (Month, Day, Year)	A A	legistrar's Signatur	000	TO CONS	July led	riguns	VIIIE	N	20'0
1	Registr		OCT 18	2006	w K.	Coest						

	1 = For State Registrar	State of Marylan	-	rtment of Ho			iene 0 0	6 34899
1977 120	Decedent's Name (First, Middle, Las.	1)				2. Date of Deat	h	3. Time of Death
Physiciar /Medica	Reela Solla	Lippo				October	06, 2°C	006 9:50 a <sup>M</sup>
Examine	4a. Facility Name (If not institution, give			4b. City, Town, or		th	4c. County of C	
	15101 Interlachen 5. Social Security Number 6. Se		last hirthday)	Silver If Under 1 Year	Spring If Under 24 Hrs	8. Date of Birth	1 9	Gomery Birthplace (State or Foreign
Funeral Director		T RD -	92 Yrs.	Months Days	Hours Min.		1914 F	Country) Finland
p .	Usual Residence of Decedent	100 00	T					
anyla ehov	10a. State 10b. County		y, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 🔀 No
vith the Ma	Maryland Montgo	mery 5.	ilver S	pring 10f. Zip Code		10	ng. Citizen of What	t Country?
3a or		Drive #606		20906			United	
office the same same same same same same same sam	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?		Vas Decedent of His Yes, specify Cubar	spanic Origin? (S	Specify Yes or No-		American Indian, Vhite, etc.
Urs after		1 ☐ Yes 2 🔼 No If Yes, Give		☐ Yes 2☑ No	Specify:		Specific	·
21215-0036  d within 72 hours at giene. Then "naturel", or the Medical Exam	3 Widowed 4 Divorced  15. Decedent's Edi	Year or Dates:	16a Deced	ent's Usual Occupa	tion	-	16b. Kind of Busine	aucasian
215	(Specify only highest grad		(Give	kind of work done di OO NOT use retired)	urina most of wo	rking	TOD. TRING OF BUSINE	sastiousity
ed within 72 horygiene. The Medical it, the Medical it.	5	College (1-40/ 37)	Hom	nemaker			Own Ho	me
Maryland 21215-0036  4 2 should be filed within 72 hours after deeth with the Maryland th and Mental Hygiene. 7 le marked other then "natural", or Iteme 23s or 28s-f show treumatic event, the Medical Examinations to rotified at	17. Father's Name (First, Middle, Last)					me (First, Middle, M	faiden Sumame)	
aryla should ind Men marke umatic		Dried	40h 14-11-	- 4 - 1 - 1 (0) 1	Unknow		0' T 0'-	7-0-11
Mal d 2 sl d 2 sl th an treur	19a. Informant's Name/Relationship (7) Tom A. Lippo / S	,		•		ural Route Number, ad: Poton		land 20854
re, Maryland 21215-0036 s 1 and 2 should be filed within 72 hours after deeth with the Marylan f Health and Mental Hygiene. Item 27 is marked other then "naturel", or iteme 23s or 28s-1 show other treumatic event, the Medical Examinar must be notified at The Re Compiled At Linears in Director	20a. Method of Disposition	20b. P	lace of Dispos	sition (Name of natory or other place	1	- T.	20c. Location - City	
More, Pages 1 ar nent of Hea nut: If Item:	1 ☐ Burial 2 ☑ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Hemovai from State	-	ıln Cremat	1	10/2006	Brentwo	od, Maryland
Baltimor permit. Pages Depertment of important: if it eny lojury or o	21. Signature of Funeral Service Licens		S1	Name and Address	s of Facility oute Fun	eral and	Crematio	n Center
	23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	lications that caused the death	n. Do not ente	er the mode of dying	LITE FIK	c or respiratory arre	st,	yland 20852 Approximate
Physician	Immediate Cause (Final disease or condition	a Corondry	ant	/	isedse			Interval Between Onset and Death UEDIS
/Medical	resulting in death)	Due to (or as a consequence	uence of):	Cry VI	136400			198413
Examiner	Sequentially list conditions,	h/		/				,
ed sold	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequent	uence of):					
executed executed an and rial-transit	that initiated events resulting in death) Last	c. Due to (or as a consequence)	uence of):					1
cate be executed physicien and the burial-transit		d						
rtifical ng phy as the	IF FEMALE:							
P.O. BOX 68760, hat the death certificate be executed dby the attending physicien and detached for use as the burial-transit Physician/Madical Example.	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta	Ideath 3 🗌	Ectopic pregnancy			23d. Date of Month	delivery Day Year
	1 Yes 2 No 9 Unknown	4⊡Pregnant at time of d 9⊡Unknown	eath 5□	Other (specify)			17071117	buy rour
	Part II. Other significant conditions co	ntributing to death but not resi	ulting in the un	derlying cause give	n in Part I.	23e. Did tob	acco use contribut	e to the cause of death?
Records, he law requires th a has been signe ge 2 should be d						1 □ Ye	s 200 No 3	Probably 4 Unknown
The law require cate has been signage 2 should b						24a. Was ar	24b. Were	a autopsy findings available to completion of cause of
<b>2</b>						autopsy perform 1 ☐ Yes 2	od? death	h? \/
Vital iicien: T certificat rector, pa	25. Was case referred to medical					ath (Check only one		
Physic aldina	I I I I I I S S S MINO		ER/Outpatient		4   Nursing F	tome 5 Reside		Specify)
DIVISION OF  To Attending Phy after death.  Director: After this  In by the funeral d	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work	at ? ′es 2 ∐ No	28d. Describe ho	w injury occurred	
JIVISIO I or Attendi after death Director: A lin by the ft	2 Accident investigation 3 Suicide 6 Could not be determined	286. Place of injury - At no	ome, farm, stre			28f. Location (Str	eet and Number of	r Rural Route Number,
DIVISION ( tel or Attending F s after death. el Director: After ed in by the funer.	4 Homicide	building, etc. (Specify	/)			City or Town	State)	
24 hour 24 hour 24 hour 24 hour 24 hour 24 fill		rsician: To the best of my kno iner: On the basis of examina and manner stated.	wledge, death tion and/or inv	occurred at the time estigation, in my op	e, date and place inion, death occu	e, and due to the ca urred at the time, da	use(s) and manner te and place, and	r as stated. due to the cause(s)
To the within To the compl	29b. Signature and title of certifier	Tomsko Ma	y Mo	29c. License	number 5 1916	0	ed. Date signed (M C+oben	onth, Day, Year)
P	30 Name and address of person who c	ompleted cause of death (Herr	23a) (Type./s	ville Pik	P. G-1	100 Roc.	kville.	MD 20852
State Registra	BOT 1 0 20	32 Hegistrar's Signa		di)				
				1000				

			for State Registrar				Ce Ce			Death	IG IVIC	illai my	Reg. No		34	900
	Physic /Medi		1. Decedent's Name (First, MET)  Eileen Sheil									2. Date of Domestin Month 10/14.	Da			of Death
	Exami		4a. Facility Name (If not insti	tution, give	street and nui	mber)		4b. City	, Town, o	r Location of			7.	. County of De		
			Suburban Hos						hesd				1	Montgon		
	Funeral Director		5. Social Security Number 569-40-8135		x □M 2 <u>M</u> F	7. Age (In yrs	s. last birthday, Yrs.		Days		Hrs. 8	B. Date of Bi (Month, D 6/16/	ay, Year)		inthplace (Sta Country) gland	te or Foreigi
	aryland ehow	_	Usual Residence of Deceder  10a. State 10b. Co			10c. C	City, Town or L	ocation					·			City Limits
	r 28a-1	recto	Maryland Mon	ntgome	ery	В	ethesd		p Code				10g. Cit	tizen of What		′es 2∭ No
	th wit	a D	8604 Bradmoo	re Dri	Lve				208	17			Uni	ited St	ates	
900	portificated in Mary I are a 12.13-0030 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: if item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at ange.	by Funeral Director	11. Marital Status 1 Never Married 2 3 Widowed 4 Divo		12. Was Dece Armed Fo 1 Tes If Yes, Giv Year or D	2 (X)No ∕e		Was Dece If Yes, sp 1  Yes		lispanic Origir an, Mexican, I Specify:	n? (Spec Puerto Ri	ify Yes or Nican, etc.)	0-	14. Race - Ar Black, W		,
eleimora Mandand 2121E 003E	nin 72 ho nin 72 ho nin "naturi Medical	Completed	15. Dec (Specify only h Elementary/Secondary (0-		le completed)	I doc 5 i	16a. Dece (Give life.	dent's Usi kind of w DO NOT	ual Occup ork done use retired	ation during most o	f working	,	16b. K	ind of Busines	ss/Industry	
2	iled with tygiene ther the	Com	17. Father's Name (First, Mid		College (1	1-40r 5+)	Homer							Own Hom	ie	
700	vid be f Wental H writed of	To Be	Harish C. Dha							18. Mother's				sumame) arrison	!	
200	Mary d 2 sho h and i 7 is ma trsums		19a. Informant's Name/Rela							and Number	or Rural I	Route Numb	er, City o	or Town, State		
9	s tand f Healt ftem 2		Sarah Linde-1  20a. Method of Disposition			20b.	Place of Dispo cemetery, cre	sition (Na	me of	, Kens:	ingt			395 ocation - City	or Town, State	
i	L. Page tment o tant: if		1 Burial 2 Crema 4 Donation 5 Oth	er (Specify)			verdale	e Par	k Cr	em. 1	1/17	/2006	Riv	verdale	Md	
a	Page and Pag		21. Signature of Funeral Ser	Vica Licens		M00956	TÎ	2 Name a libad 33 Ci	nd Addre eau ]	ss of Facility Mortual	ry S	ervice	P.	A. ng, MD	2091	0
			23a. Part1. Enter the diseas shock, or heart failure.	e, or compl List only o	ications that c	aused the dea	ath. Do not en	ter the mo	de of dyin	g, such as ca	rdiac or i	respiratory a	rrest,	TIR • LID	Approxin Interval E Onset ar	nate Between
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)			opulmo	nary Ar	rest							Oliset al	
	Examiner	er	Sequentially list conditions,		Coron	ary Ar	tery Di	seas	e				_			
10	ocuted nd transit	amlu	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	<b>【</b>	0.											
00	ficate be executed physician and ts the burial-transit	Aedical Examin	resulting in death) Last		Due to (	or as a conse	quence of):									
10/14/06	. = 5.6	Physician/Med	IF FEMALE: 23b. Was decedent pregnan in the past 12 months?	t 2		come of pregrinth 2 Fet	al death 3	⊒Ectopic p ⊒ Other (s						23d. Date of d Month	elivery Day	Year
= 0	at the de	Physi	1 ☐ Yes 2 🔯 No 9 ☐ Unknown		9□ Unkno	own										
	w requires that been signed should be de	b	Part II. Other significant cor	editions cor	ntributing to de	ath but not re	sulting in the u	nderlying	cause givi	en in Part I.	_			ise contribute ŽNo 3 □ I		
tiuth	The law in a te has be page 2 sh	Completed		<del></del>							_	24a. Was auto perfo 1 Yes	psy ormed?	death?	autopsy finding completion o	s available cause of
te Lett	Physician: This certifical	Be (	25. Was case referred to me examiner?	dical						26. Place of	Death /		-			
7	Physic this o	မ	1 ☐ Yes 2 ☐XNo	F			☐ ER/Outpatier	nt 3 D	Othe Othe	ər: 4 🗌 Nursii	ng Home	5 ☐ Resi	dence	6 □Other (Sp	ecify)	
	5 <u>5</u> 5	atlon;	27. Manner of Death  1 ☑ Natural 5 ☐ Pe  2 ☐ Accident Inv	nding estigation	28a. Date of	of Injury th, Day Year)	28b. Time of Injury	f M	28c. Injun Worl	/at ⟨? Yes 2 ☐ No	i	d. Describe	how injur	y occurred		
LINDE, Division	ital or Attendii rs after death. al Director: A	Certification;	3 Suicide 6 Co 4 Homicide de	uld not be termined	28e. Place buildin	of Injury - At h	nome, farm, str ify)	reet, factor	y, office		28	Location ( City or To	Street an wn, State	d Number or I	Rural Route Ni	um ber,
	To the Hospital or within 24 hours after To the Funeral Direction completely filled in b	edical	29a. Certifier 1 X Cart (Check only 2 Med one)	ifying Physical Exami	sician: To the nar: On the ba and mann	asis of examin	iowledge, deatl ation and/or in	h occurred vestigation	at the tim	ne, date and pointion, death of	olace, and	d due to the at the time,	cause(s) date and	and manner a place, and du	is stated. le to the cause	9(s)
	MA.	Σ	29b. Signature and title of ce	rtifier	toll-	7		29		number D600	887	7	29d. Dat	e signed (Mg	th, Day, Year,	)
	ID		30. Name and address of per	so 0 co	empleted cause	e of death (Ite	m 23a) (Type,	Print)	-					1 01		
			Jack L. Flyer				sin Ave	., C	nevy	Chase,	MD	2081	5		7	
	Sta Registi		31. Date filed (Month, Day, Y			gistrar's Sign	k dos	will								

			1- FoAmend #26 per F		1/02/66	epartmer Certificat	t of H	ealth a	nd Me	ental Hyg	ene () (	6	34901
	Physici	an	Decedent's Name (First, Middle, Last,							<ol> <li>Date of Deatle</li> <li>Month</li> </ol>	Day	Year	3. Time of Death
	/Medic	al	Carl Kent Mar  4a. Facility Name (If not institution, give			4h City	Town or	Location of		October	15, 2 4c. County		7:00 a <sup>M</sup>
	Examin	ıer	Sunrise Assisted			40. 0.0,		apolis			1		undel
	Funeral	222	Social Security Number     6. Security Number	7. Ag	θ (In yrs. last birth	day) If Unde Months	1 Year	If Under 2		8. Date of Birth (Month, Day,			place (State or Foreign
	Director		578-12-1344	XM 2□F	84 Y	rs.	Days	nouis		June 24			WV
	and		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town	or Location						- 1	IOd. Inside City Limits
	Mary Fied	ţō	MD Anne A	rundel		Arnol	d						1 ☐ Yes 2 No
	th the	Director	10e. Street and Number		1	10f. Zij				10	g. Citizen of	Vhat Cour	ntry?
	ath wi	ral	175 Dividing Cour					21012				SA	
	Rems Darr	Funeral	11. Marital Status 1 ☐ Never Married 2 ★ Married	12. Was Decedent Armed Forces? 1 ☐ Yes 2 ☑!		13. Was Dece If Yes, spe	dent of Hi cify Cuba	spanic Origi n, Mexican,	in? (Spec Puerto R	cify Yes or No- lican, etc.)		e - Americ k, White,	can Indian, etc.
920	urs af	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	••	1 🗆 Yes	2 <b>X</b> No	Specify:			Specify	. Wh	nite
ς Ο	tiled within 72 hours after death with the Maryland Hygiene. ther then "natural", or liems 23a or 28a-f show shif, the Madical Examinat must be notified at	Completed	15. Decedent's Edu (Specify only highest grad		16a. [	Decedent's Usu 'Give kind of wo	al Occupa	ition	of working	a 1	6b. Kind of B	usiness/In	dustry
2	vithin ne. hen "	mple	Elementary/Secondary (0-12)	College (1-4or 5	5+)	life. DO NOT u	se retired,	)			Envir		ntal
15 D	Hygie ther t	ပ္ပ	17. Father's Name (First, Middle, Last)	4		Civil E	ngın		's Name	(First, Middle, N	Eleme:		
<u>lan</u>	hental rked o	To Be	Rex Martin							Scholz		,	
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Madical Examinat must be notified at an ance.		19a. Informant's Name/Relationship (Ty	рө, Print)	19b. I	Mailing Address	(Street a	nd Number	r or Rural	Route Number,	City or Town,	State, Zip	Code)
S G	1 and Health Im 27 Ther tr		Gilda M. Martin/V	Wife	1° 20b. Place of E			Court	, Ar	mold, M	D 210		Chata
Baltimore,	ages nt of h t: If its		1 ☐ Burial 2 ☐ Cremation 3 ☐ F		cemetery	crematory or c	other place	<sup>g)</sup> C	ct.	17,			
	artme ortani injury		4 Donation 5 Other (Specify) 21 Squatur of Funeral Service Cens	-1	riccio	22. Name a	nd Addres	s of Facility	, , ,		Baltim		
ä	Pen Pen Pen Pen Pen Pen Pen Pen Pen Pen	1	Somes tox 19	Man	20	Barra	nco 8	& Sons	s, P.	A. Seve	rna Pa: rna Pa:	rk Fu rk. №	neral Home D 21146
	# -886.	6	a. Pa 1. Enter the disease, or compleshock, or heart failure. List only or	ications that caused ne cause on each lin	I the death. Do no								Approximate Interval Between
	Pnysician	1	Immediate Cause (Final disease or condition resilting in death)		RKINSO.			FASE					Onset and Death
	/Medical Examiner	-	resulting in death)	Due to (or as	a consequence of	r):							1
難	1 to 1	e.	Sequentially list conditions, if any, leading to immediate	Due to (or as	a consequence of	7:						+	
	d ansit	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events										
Ö,	ate be executed hysician and the burial-transit	Exe	resulting in death) Last		a consequence of	·):							
8760,	cate be executed oblysician and the burial-transit	dlcal		d								-	
9	eath certific attending p	Physician/Me	IF FEMALE:	3c. If yes, outcome	of pregnancy						22d Day	e of delive	<b></b>
Вох	death a atten d for u	clar	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	1 □Live birth 4□ Pregnant at	2 Fetal death	3 □Ectopic p 5 □ Other (s <sub>i</sub>					Mo		Day Year
P.0.	at the by the tacher	hys	9 Unknown	9□ Unknown									
	The law requires that the death certific tle has been signed by the attending p page 2 should be detached for use as:	by	Part II. Other significant conditions con	ntributing to death b	ut not resulting in t	the underlying o	ause give	n in Part I.					ne cause of death?
ord	requii	Completed								1 Tye	s 241No	3 Prob	ably 4 Unknown
3ec	e law has b	mple								24a. Was an autopsy perform		Vere auto prior to con death?	psy findings available mpletion of cause of
a	iician: The lav certificate has rector, page 2	e Co	25. Was case referred to medical		_			00.51	(D) #	1 ☐ Yes 2	ANO 1		2 No
<u>=</u>	Attending Physician: r death. sctor: After this certification the funeral director.	To B	examiner?	fospital:	ont 2□ER/Outc	patient 3 D	Othe	r	emg Hom	<i>(Check only one</i> e 5 ☐ Residei		ar (Specifi	Assisted DLiving
0	ng Ph Iter th neral		27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	ry 28b. Tir	me of 2	8c. Injury			d. Describe ho	w injury occur	ed	"LIVING
Sio	tendii leath. tor: A the fu	catle	2 Accident investigation 3 Suicide 6 Could not be			М		res 2□N					
Division of Vital Records,	lor At after d Direct in by	Certification:	4 Homicide determined	28e. Place of Injuding, et	ury - At home, fam c. <i>(Specify)</i>	n, street, factor	y, office		28	3f. Location (Str. City or Town,		er or Rura	d Route Number,
_	To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate he completely filled in by the funeral director, page		29a. Certifier 1 Certifying Phys	sician: To the best	of my knowledge,	death occurred	at the tim	e, date and	place, an	nd due to the ca	use(s) and ma	nner as s	tated.
	he Ho in 24 I he Fu pletely	edical	(Check only 2 Medical Exami	ner: On the basis of and manner sta	examination and/	or investigation	, in my op	inion, death	occurred	d at the time, da	te and place,	and due to	the cause(s)
	To t To t	Σ	29b. Signature and the of certifier	. 1			c. License		1/	29	d. Date signe	(Month,	Day, Year)
•			11 1000				15	706	. 7		(0)	6/0	76
	5		30. Name and address of person who co	Ser lein	eath (Item 23a) (T	ype, Print)	chinci	ale Fe	-n /	2/ /	trudd	MO	21012
	Sta	ite	31. Date filed (Month Day, Year)	-	ar's Signature					·	,		
10.	Registr	ar	201 - 0 200	JO Juga	· K	hand .							

DHMH 17 Rev 1/2001

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible, State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Thomas John McCauley October 2006 10:34 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Anne Arundel Medical Center Annapolis Anne Arundel 8. Date of Birth (Month, Day, Year) Jan. 21, 1934 If Under 1 Year | If Under 24 Hrs Months Days | Hours Min. 6. Sex 1**XX**M 2□ F 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Minnesota Director 578-42-4652 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10b. County 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2XXIIo Director Anne Arundel Annapolis Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a any Injury or other traumatic event, the Medical Examiner must bonce. Funeral 130 Hearne Ave. 21401 United States 12. Was Decedent Ever in U.S. Armed Forces? 1953 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian. Black, White, etc. 1XXYes 2 □ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1955 1 □ Yes 2XXNo Specify Specify: ģ 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Department of Elementary/Secondary (0-12) College (1-4or 5+) Parks and Recreation Natural Resources 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ( Lucille Crahan Norbert McCauley ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Crofton, Maryland 21114 Kim McCauley / Nephew 1417 Ormsby Place 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 20c. Location - City or Town, State MYBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Crownsville Vet. Cem. 10/23/06 Crownsville, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility John M. Taylor Funeral Home, Inc. 147 Duke of Gloucester St. Annapolis, MD 21401 23a. Part1. Enter the isease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Mutsute C Due to (or as a nsequence of): **Physician** /Medical **Examiner** Sequentially list conditions, if any, learning to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 ✓ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform certificate 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 ☐ Yes 2 N 1 Impatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Mann eath 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending Injury

Division or Vital Records, P.O. Box 68760,

the Hospital or Attending Physician: The law requires that the death certificate be executed After

n 24 hours after death.

le Funeral Director: A pletely filled in by the fu

funeral

2 ☐ Accident

3 ☐ Suicide

29a. Certifier (Check only one)

4 ☐ Homicide

State Registrar

Medical

and manner stated. 29b, Signature and title of cortifier

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

> 29c. License number D00058297

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year) 10

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2001 Medical Parkway MD Medical Contr Annedon sel

HOWARDYOUN 31. Date filed (Month, Day, Year) 1 8 2006 OCT

investigation 6 Could not be determined

egistrar's Signature

within 2

			Please Type or Print in				•		
			State of Maryla		partment of H <i>ertificate of I</i>		ental Hy	giene	01000
	0,	-1	Registrar  1. Decedent's Name (First, Middle, Last)		ortimoato or i	Joann	2. Date of De		3. Time of Death
SQ.	Physici /Medic		George Harold	M	1itchell		Octobe	r 16 2006	1607 <sup>M</sup>
	Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Annapo	Location of Death		4c. County of Dea	
A-7	Funeral		Anne Arundel Medical Center  5. Social Security Number 6. Sex 7. Age (In yr	rs. last birthda	ay) If Under 1 Year	If Under 24 Hrs.	8. Date of Birt	th 9. Bi	rthplace (State or Foreign
.a.	Director		239-38-0279 <sup>1</sup> M <sup>2</sup> □ F 77	Yrs.	Months Days	Hours Min.	June 30	y, Year) No:	rth Carolina
	and		Usual Residence of Decedent         10a. State         10b. County         10c. 0	City, Town or	Location				10d. Inside City Limits
	Maryl Ff sho fied a	tor	MD Anne Arundel	Annap	oolis				1 □Yes XXNo
	ith the or 282 e noti	Director	10e. Street and Number		10f. Zip Code			10g. Citizen of What C	ountry?
	s 23a nust b	eral I	2700 South Haven Road  11 Marital Status  12. Was Decedent Ever in	116 4	2140		oif. Van av Na	USA - 14. Race - Am	orican Indian
	be filed within 72 hours after death with the Maryland the Hydjene.  In Hydjene.  In a chief than "natural", or items 23a or 28a-f show event, the Medical Eximiner must be notified at	Funeral	1 Named Forces?	0.5.	<ol> <li>Was Decedent of H If Yes, specify Cuba</li> </ol>		Rican, etc.)	Black, Whi	te, etc.
5-0036	ours a ral", o Exam	l by	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates: Ko1	rean	1 ☐ Yes 2X No	Specify:		Specify:	White
2-0	n 72 h "natu edical	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Ded (Gi	cedent's Usual Occup ive kind of work done of e. DO NOT use retired	ation during most of worki	ng	16b. Kind of Business	s/Industry
7	withir iene. than	omp	Elementary/Secondary (0-12) College (1-4or 5+)	- 1	ımber	"		Plumbin	g
פַ	e filed al Hyg other vent, 1	Be C	17. Father's Name (First, Middle, Last)			18. Mother's Name	(First, Middle,	Maiden Surname)	-
ylar	Menta Menta arked aric e	<b>To E</b>	W. Pridgen			Elizabe	th Mitc	hell	
Maryland 2121	permit. Pages 1 and 2 should be filed will be perment of Health and Mental Hygien Important: if item 27 is marked other th, any injury or other traumatic event, the once.		19a. Informant's Name/Relationship (Type. Print)  Christine B. Carter (Sister)		-			er, City or Town, State, olis, MD 2	• •
	Healt Healt tem 2				sposition (Name of rematory or other place		ate	20c. Location - City o	
altimore,	Pages nent of int: If i		1 Bunal 2 Notemation 3 Hemoval from State		rematory or other plac rematory	10-18	-2006	Baltimore	, MD
alti	epartn epartn nporta ny inju		21. Signature of Pyneral Service Licenses		22. Name and Addres	ss of Facility Funeral	Home, P	·.A.	
<u> </u>	20529		23a. Part1. Enter the disease, or complications that caused the de	acth. Do not a	12 Ridge	<u>ly Avenue</u>	<b>,</b> Annap	olis, MD 2	1401 Approximate
	Obvolejen		shock, or heart failure. List only one cause on each line.	-				nest,	Interval Between Onset and Death
1	Physician /Medical		disease or condition resulting in death)  a. Due to (or as a const	equence of):	ephalog Prem	xxx hy			
	Examiner		Sequentially list conditions.		Pren	monia			
	ped isit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	equence of):					
90,	be executed cian and ourial-transit	Examiner	that initiated events resulting in death) Last	equence of):					
376(	eath certificate be ey attending physician for use as the buria	cal							
x 687	entifica ding ph	/Med	IF FEMALE: 23c. If yes, outcome pf preg	nanov					
Вох	leath c attend	Physician/Medica	23b. Was decedent pregnant in the past 12 months?  1 ☐ Yes 2 ☐ No	etal death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)	′		23d. Date of de Month	Day Year
P.O.	it the c by the tached	hysi	9 Unknown				1		
ς Υ	The law requires that the death certificate be executed the has been signed by the attending physician and oage 2 should be detached for use as the burial-transit	by	Part II. Other significant conditions contributing to death but not re	esulting in the	e underlying cause giv	en in Part I.		obacco use contribute i	
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<u> </u>	hysici his cel I direc	To B	examiner? 1 ☐ Yes 2 ☐ Hospital: 1 ☐ Impatient 2		tient 3 DOA Oth	4   Nursing Ho	me 5□Resid	dence 6 ☐Other (Spe	ec <i>ify)</i>
o uc	ding Physician: The In. After this certificate hat funeral director, page		27. Manner of Death 28a. Date of Injury (Month, Day Year)	28b. Time Injury	y Wor	y at k? Yes 2 □ No	28d. Describe I	now injury occurred	
Division or	deatl deatl ctor: y the	ficat	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of injury - At the determined suit the country - At t	t home, farm,				Street and Number or F	Bural Route Number,
	s after al Dire	Certification:	4 Homicide determined building, etc. (Spe	ecity)			City or Tou	vn, State)	
	To the Hospital or Attenwithin 24 hours after death to the Funeral Director: completely filled in by the		29a. Certifier 1 Certifying Physician: To the best of my k 2 Medical Examiner: On the basis of exami						
	o the ithin 2 o the omple!	Medical	one) and manner stated.  29b. Signature and title of certifier.		29c. Licens	e number		29d. Date signed (Mor.	ith, Day, Year)
)	(1)	<		>	Doo	05829	7	10/16/	2006
•	tiva		30. Name and address of person who completed cause of death (It H. Youw MD Anne Aran)	tem 23a) (Typ	pe, Print) Drcl Car	te An	napoli	10/16/ S MD Z	:401
	Sta Registi		31. Date filed (Month Day, Year)  32. Registra Sig	gnature	* Should	,	1		•
				-	14				

		1 - For State Registrar	State of Mary	•		of Health an		Reg. No.	006	34904
Physici		1. Decedent's Name (First, Middle, Last)  Charles E. N	loraan				2. Date of Month	Death Day	<b>100</b>	
/Medic Examir		4a. Facility Name (If not institution, give			4b. City, T	own, or Location of D			County of De	ath
		University of Mar. 5. Social Security Number 6. Sec.	yland Med	yrs. last birthday	If Under 1			Birth	1/1 <del>4</del>	irthotace (State or Foreign
Funeral Director		132-24-4527	7M 2 7 F	3 Yrs.			Min. (Month, Octobe	Day, Year)		irthptace (State or Foreign Country) New York
and w		Usual Residence of Decedent  10a. State 10b. County	100	. City, Town or L	ocation					10d. Inside City Limits
ith the Marylan or 28e-f ehow	tor	Florida Clay		Green Co	vo Snr	ince				1X Yes 2 □ No
th the	Funeral Director	10e. Street and Number		reen co	10f. Zip (			10g. Citi:	zen of What C	Country?
ath will	raiD	411 Walnut Street				043			ed Sta	
items	une	11. Marital Status 1 ☐ Never Married 2 ☑ Married	12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 X No	in U.S.   13.	Was Decede If Yes, speci	ent of Hispanic Origin' fy Cuban, Mexican, P	? (Specify Yes or uerto Rican, etc.)	No-	Black, Wh	nerican Indian, nite, etc.
permit. Pages 1 and 2 should be filed within 72 hours effer death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural; or Itema 23e or 28e-f ehow important: If Item 27 is marked other than "natural; or Itema 20e or 28e-f ehow purp or other traumatic event, The Medical Examinal must be conflicted at once.	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2	₩ No Specify:			Specify: W	hite
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12 should and 7 is m		19a. Informant's Name/Relationship (Ty				(Street and Number o				
Healt Healt tem 2		Jaye Morgan Tower/ 20a. Method of Disposition		b. Place of Disp	osition (Nami	e of	Date			icut 06013 or Town, State
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permit. Departminentalimportal		21. Signature of Puneral Service License	00			Address of Facility	Crouch			
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w requirements	leted						24a. W	as an	24b. Were	autopsy findings avaitable
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Physic this o	2	1 XYes 2 No 27. Manner of Death	Hospital: Inpatient	2 ER/Outpatie			ng Home 5 ☐ Ri			pecify)
th.: After	tion	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Yea	ar) Injury	м	3c, Injury at Work? 1 ∐ Yes 2 ∐ No		o non injur	, 00001100	
r Atter	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - building, etc. (S	At home, farm, s	treet, factory,	office		(Street and Town, State)		Rural Route Number,
urs aft										
To the Hospital or Attending Physicien: The law requires that the death certificate within 24 hours after death.  To the Funeral Director: After this certificete has been signed by the etlending physicompletely filled in by the funeral director, page 2 should be detached for use as the	dicai		sician: To the best of my iner: On the basis of exa and manner stated.							
To the Complex	₹	29b. Signature and title of certifier	0	_		License number		1	-	nth, Day, Year)
		1 aules	ful Ms	Pesider	A D	63939		00	18	2006
		30. Name and address of person who co	ompleted cause of death	(Item 23a) (Type	, Print)	63939 5treet,	Ball:	M	ΔΩ	9 17 21
Sta	ate	31. Date filed (Month, Day, Year)	2. Registrar's	Signature /	cene	31.00	1/2017	were_	(N 17	L110
Regist		nct 2 o 2006	Hours.	15. 1500	ALL					

			For State Registrar	State of I	Maryland / Dep <i>Ce</i>	artment of l			giene Reg. No.200	6 34905
			Decedent's Name (First, Middle,	Last)				2. Date of De Month		3. Time of Death
	Physici /Medic		FLORENCE		NUTTI		DNALD	Oct	ober 18,	200f 8:05 AM
*	Examin	er	4a. Facility Name (If not institution,		er)	4b. City, Town, o		Death	4c. County of	
	Francis		2562 Hickman L 5. Social Security Number	6. Sex 7.	Age (In yrs. last birthday	If Under 1 Year		4 Hrs. 8. Date of Bin	Wicos	. Birthplace (State or Foreign
	Funeral Director		218-20-8824	1□M 2∰F	79 Yrs.	Months Days	Hours	Min. (Month, Da	, 1926 M	(Country) Laryland
	pu *		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside City Limits
	Maryla ( •ho	ō	Maryland Wicom	ico	Nantio					1 ☐ Yes 2 No
	1 the	irec	10e. Street and Number	200		10f. Zip Code			10g. Citizen of Wha	at Country?
	J within 72 hours after death with the Maryland Jiene. Tiene. Tratural; or Iteme 23e or 28e-f ehow I're Madical Examiner must be notified at	Funeral Director	2562 Hickman La	ne			1840		US	
	er dea	unei	11. Marital Status	12. Was Decede	ent Ever in U.S. 13.	Was Decedent of I If Yes, specify Cub	Hispanic Orig an, Mexican,	in? (Specify Yes or No Puerto Rican, etc.)	14. Race - Black,	American Indian, White, etc.
36	Irs aft	by F	1 Never Married 2 Married 3 Widowed 4 Divorced	ed 1 Tes 2 If Yes, Give Year or Date		1 ☐ Yes 2¶ No	Specify:		Specify:	Black
21215-0036	72 hot	ted	15. Decedent' (Specify only highest		16a. Dece	edent's Usual Occu	pation during most	of working	16b. Kind of Busin	ness/industry
21	within in energy the west	Completed	Elementary/Secondary (0-12)	College (1-4	or 5+)	DO NOT use retire	id)			City Public
42	filed w Hygier ther ti	e Co	17. Father's Name (First, Middle, L	6+ 	Educ	ator/Princ	_	's Name (First, Middle	School Sy , Maiden Surname)	ystem
Maryland	s 1 and 2 should be filed f Health and Mental Hyg Itam 27 Is marked othe other traumatic event,	To Be	Reuben		Nutt		Anni			White
Mar	nd 2 sh ulth and 27 is m r traum		19a. Informant's Name/Relationsh Oswald Nutter/ne					r or Aural Route Numb Nanticoke,		
a)	of Health Itam 27		20a. Method of Disposition		20b. Place of Disc			Date Date	20c. Location - Cit	
Ë	Pages nent of int: If it iry or o		1 ABurial 2 □ Cremation 4 □ Donation 5 □ Other (Sp		318	•		0/21/2006	Nanticoke	, Maryland
Baltimore,	permit. Pages Depertment of I Important: If Itt eny Injury or o		21. Signature of Funeral Service L	censee Incles	2	22. Name and Address	ess of Facility		ey Road -	Salisbury, MD 21801
			23a. Part1. Enter the disease, or shock, or heart failure. List of	complications that can	sed the death. Do not en	nter the mode of dy	ng, such as	cardiac or respiratory a	rrest,	Approximate Interval Between Onset and Death
Ř	Physician		Immediate Cause (Final disease or condition resulting in death)	-a End	Stage	Parkin	1502	נו		Oriset and Death
	/Medical Examiner		resulting in deality	Due to (or	as a consequence of):					
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9	tificate ig phy as the	ledic		0.						
Вох	eath certific attending pl for use as t	an/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outco	h 2 Fetal death 3	□Ectopic pregnanc	:y		23d. Date of	
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Δ.	that the		Part II. Other significant conditio	ns contributing to dea	th but not resulting in the	underlying cause g	ven in Part I.	23e. Did t	tobacco use contribu	ute to the cause of death?
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900	law reas bee	Completed						24a. Was	an 24b. We	re autopsy findings available or to completion of cause of
œ	The la	Com						perfo	ormed? / dea	ith? ]Yes 2□ No
Vital	Physiclan: Th this certificete ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:			har	of Death (Check only		
of	Phys this raldia	To	1 ☐ Yes 2 ☑ No 27. Manner of Death	28a. Date of	njury 28b. Time	ant 3LI DUA	4 🔲 INUI		dence 6 Other how injury occurred	
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Division	l or Atte efter de Directo d in by th	Certification;	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi	ned 286. Place 0	f Injury - At home, farm, s g, elc. <i>(Specify)</i>	treet, factory, office		28f. Location ( City or To		or Rural Route Number,
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	within 2 To the comple	Me	29b. Signature and title of certifier	1000011	M.	29c. Licen	se number		29d. Date signed (	Month, Day, Year)
	103		•	Sylection		ì	005	7333	10/	19/06.
	1000		30. Name and address of person	who completed cause	of death (Item 23a) (Type	e, Print)		Salval		2100/1
-	Sta	ate	31. Date filed (Month, Day, Year)	100	gistrar's Signature	Shone	DO,	JULIS DAN	7, MD	618 7
龙	Regist	rar	OCT 1	9 2006	due & A	marie				

			1 - For State Registrar	State of Mary				ealth and Death	l Mental I	Hygie Reg.	_/	)6	349	06
	Physici		Decedent's Name (First, Middle, La	Dora MO	SENKIS				2. Date of Month	f Death	Day 8, 20	Year 06	3. Time of Do	
/	/Medic Examir		4a. Facility Name (If not institution, giv	_				Location of De			4c. County	of Death		21
			Holy Cross Hospi  5. Social Security Number 6.5		n yrs. last birthday)			Spring If Under 24 H	rs 0.0	( Diah	Mont	<del>-</del>		
	Funeral Director		070-64-6924	1 □ M 2 X F	86 Yrs.	Months		Hours Mi		17,	1920	Pola	place (State or F ntry) and	Foreign
	iand wo		Usual Residence of Decedent  10a. State 10b. County	10	c. City, Town or Lo	cation						1	10d. Inside City	Limits
	Mary	ţō	New York King	s	Brook	lyn							1 ☐ Yes 2	X No
	ith the	Director	10e. Street and Number			10f. Zi	p Code			10g.	Citizen of V	hat Cour	ntry?	
	eth w	rai	3161 Brighton 6th	<del></del>			.1235				ited			
036	is 1 and 2 should be filed within 72 hours after deeth with the Maryland of Heelth and Mental Hygiene. Itsm 27 ie marked other than "natural", or itams 23a or 28a-f ehow other traumatic event, the Madical Examinational La notified at	by Funerai	11. Marital Status  1 Never Married 2 Married  3 Microed 4 Divorced	12. Was Decedent Ever Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	1		edent of Hi. ecify Cubai 2 XNo	spanic Origin? n, Mexican, Pu Specify:	(Specify Yes o arto Rican, etc.	r No- )		c, White,		
Maryland 21215-0036	n 72 ho	Completed by	15. Decedent's E (Specify only highest gra		16a. Deced	dent's Usu	al Occupa	ution lu <i>ring</i> most of w	vorking	16t	. Kind of Bu	siness/In	dustry	
717	withir iene.	ошо	Elementary/Secondary (0-12)	College (1-4or 5+)	Į.	esper	,	,		G	rocer	v Sto	ore	
פ	e filed al Hyg other	BeC	17. Father's Name (First, Middle, Last,	)				18. Mother's N	ame (First, Mic	_				
ylaı	should b nd Ments marked umatice	To		s Dermer					ah Shoe					
	and 2 sh belth and n 27 le m		19a. Informant's Name/Relationship ( Michael Mosenkis,		19b. Mailin 10716	og Addres Gai	s (Street a	nd Number or i	oad, Po	toma	ty or Town,		854	
Baltimore,			20a. Method of Disposition 1   Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specif	M ronnovannom State	20b. Place of Dispo cemetery, cren ashingtor				Date 19/06		Location -	•		
Balti	permit. Page Department Importent: I any Injury o		21. Signature of Funeral Service Licer		Ť	Name a	nd Addres nsky	s of Facility Hebrew	Funera	.1 Ho	me			
			23a. Part1. Enter the disease, or com	plications that caused the				L St., , such as cardi			ton,	DC 2	20012 Approximate	
	Physician		shock, or heart failure. List only Immediate Cause (Final disease or condition	a Sepsis								1	Interval Between Onset and Dea	en ath
	/Medical Examiner		resulting in death)	Due to (or as a co	onsequence of):							1	10015	
H		er	Sequentially list conditions, farry, leading to him characause. Enter Underlying Cause (Disease or injury	b. Bowel per	foration on the second of the							F	lours	
	and I-transit	Examin	Cause (Disease or injury that initiated events resulting in death) Last	c. Metastati Due to (or as a co	c Cancer	Unk	nown	Primar	у			(	One Mont	th
8/60,	ficate be executed physicien and is the burial-transit	dicai E		_ d.	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,									
٥	ertifica ling ph	Φ.	IF FEMALE:											
O. BOX	that the death certific hed by the attending p	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 □Yes 2▼No 9 □Unknown	23c. If yes, outcome of pr 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3	Ectopic p Other (s				_	23d. Date Mon		ery Day Yea	ìr.
ds, r	80 50	ρ	Part II. Other significant conditions of	ontnbuting to death but no	ot resulting in the un	nderlying	cause give	n in Part I.					ne cause of deat	
Hecord	~ 07	Completed							24a. V	√as an	24b. W	ere autor	psy findings ava	ailable
-	The ete h page	Com							a p 1 □ Ye	utopsy erformed s 2 🗗	? de	eath?	npletion of caus 2□ No	se or
Vital	Physician: The this certificete ral director, pag	o Be	25. Was case referred to medical examiner?	Hospital:	. X		Othe	r	eath (Check or					
	the state	-	1 Yes 2 XNo  27. Manner of Death 1 Xeatural 5 Pending	28a. Date of Injury (Month, Day Yea	2 ER/Outpatient 28b. Time of Injury	1	28c. Injury Work	at ?	Home 5 R		6 □Othe		′)	
UNISION	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the funeral Director.	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined		At home, farm, stre	M eet, factor		es 2□No	28f. Locatio	n (Street	and Numbe	r or Rura	l Route Number	r,
2	pital or urs afte eral Dir illed in									Town, St	·			
	To the Hospital or At within 24 hours after o To the Funeral Direct completely filled in by	edicai	29a. Certifier 1 A Certifying Ph (Check only one) 2 Medical Exam	nysician: To the best of my niner: On the basis of exa and manner stated.	imination and/or inv	occurred restigation	at the time	e, date and plac inion, death occ	ce, and due to to curred at the tin	the cause ne, date a	e(s) and man and place, a	ner as stand due to	ated. the cause(s)	
	To the To the comp	×	29b. Signature and title of certifier	Wi-	0	29	c. License				Date signed		•	
	3		1 1	White M			D (	0043539		0	ctobei	18,	, 2006	
			30. Name and address of person who				0.27	lmor C	and an a 34	m 0	0010			
	Sta	te	Raymond White, M. 31. Date filed (Month, Day, Year)	329Registrar's S			, S1.	rver Sp	ring, M	<u>ע</u> 2	0910			
	Registr	ar	OCT 1 9 20	106	Signature for									

7. Age (In yrs. last birthday)

72 Yrs.

Certificate of Death

4b. City, Town, or Location of Death

If Under 1 Year If Under 24 Hrs.

Hours

Rockville

Days

9. Birthplace (State or Foreign Country)
Washington, DC

10d. Inside City Limits

1XXYes 2 ☐ No

3. Time of Death

8:50 a M

iene	n	Π	5	3	60 mm 100	Q	n
ig. No.	U	$\cup$	U	0	1	1	0

Year

Montgomery

2006

2. Date of Death

October

8. Date of Birth
(Month, Day, Year)
Sept. 20,1934

Month

Day

15,

4c. County of Death

10g. Citizen of What Country?

Specify:

16b. Kind of Business/Industry

20c. Location - City or Town, State

23d. Date of delivery

Day

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

Year

Month

23e. Did tobacco use contribute to the cause of death?

29d. Date signed (Month, Day, Year)

October 15, 2006

24a. Was an autopsy performed?

1 Yes 2 X No

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 StUnknown

Brentwood, Maryland

Approximate Interval Between Onset and Death

United States

14. Race - American Indian. Black, White, etc.

White

Government Contracting

**Physician** /Medical Examiner 1. Decedent's Name (First, Middle, Last)

Evelyn

5. Social Security Number

220-28-6885

Μ.

4a. Facility Name (If not institution, give street and number)

Miller

1 □ M 203 F

Shady Grove Adventist Hospital

6. Sex

**Funeral** Director

> 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Center Drive Rockville, MD 9901 Falk Medica 31. Date filed (Month, Day, Year) 32 Registrar's Signature OCT 19 2006 ORIGINAL

DHMH 17 Rev 1/2001

State

Registrar

Brandon

		1 - State of Maryland / Department of Health and No.  Certificate of Death		iene () ()	16 34908
Physici		1. Decedent's Name (First, Middle, Last)  Miriam T. Nash	2. Date of Deat Month	Day	Year 12:55 P M
/Medic Examin		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death  Futurecare Chesapeake  Arnold		4c. County	2 G G
Funeral Director		5. Social Security Number 215-24-5484  6. Sex 1 Merit Merit Merit Merit Months Days Hours Min.  7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Mar. 21	Year)	9. Birthplace (State or Foreign Country) Maryland
death with the Maryland ms 23a or 28a-f show tribat be nutfled at	tor	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location  MD Anne Arundel Arnold			10d. Inside City Limits 1 ☐ Yes 2√ No
vith the I	Director	10e. Street and Number 10f. Zip Code	1	0g. Citizen of W	
16 Te	by Funeral	443 Century Vista Road  11. Marital Status  1 □ Never Married 2 ⋈ Married 3 □ Widowed 4 □ Divorced  21012  12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ⋈ No If Yes, Give Year or Dates:  1 □ Yes 2 ⋈ No Specify:	pecify Yes or No- Rican, etc.)	14. Race	USA e-American Indian, k, White, etc. : White
Z I Z I 3-0030 d within 72 hours af giene. er then "natural", or the Wedlest Exem	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  12  16a. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired)  Homemaker	king	16b. Kind of Bu	siness/Industry  Home
Mental Hygarked otherstrand	To Be C	17. Father's Name (First, Middle, Last)  Alfred Epp  18. Mother's Nam  Barl	ne (First, Middle, M bara Ihle		ə <i>)</i>
i, IVICII) and 2 sho salth and I n 27 is mu		John M. Nash/Husband  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Run  443 Century Vista Rd.	. Arno	City or Town, 1	
permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumetic so once.		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)  21 Signature: Repeat Service Licensee	et. 19, 2006	Miller	City or Town, State
Depariment of the part of the		Barranco & Sons, P. 495 Cov. Ritchie H. 23a. Parti. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac			rk Funeral Home rk, MD 21146
Physician / Medical Examiner bhysician and street physician and street physician and street physician situation and street physician situation and street physician street physi	dical Examiner	shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):			Interval Between Onset and Death
death certiff e attending of for use as	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes   2 MNo   9   Unknown   9   Unk		23d. Date Mon	e of delivery tth Day Year
w requires that I	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  CEREBROVASCULAR PISEASE	23e. Did tob	A	ibute to the cause of death?  3 Probably 4 Unknown
The law requires that the are has been signed by the page 2 should be detached.	Completed		24a. Was an autops perform	y p ned? d	Vere autopsy findings available rior to completion of cause of eath?
To the Hospitel or Attending Physician: The law within 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2.	Certification; To Be	examiner / 1	28d. Describe ho	ence 6 Othe	
Hospitel or / 4 hours after unerel Dire	edical CertII	4 Homicide  determined  208. Place of my finding, affir, affire, family street, factory, office building, etc. (Specify)  29a. Certifier (Cneck only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occur.	City or Town	n, State)	nner as stated.
To the t within 24 To the Complete	Medi	29b. Signature and title of certifier  Museg MD  29c. License number  DE 7531	29	9d. Date signed	(Month, Day, Year)
5	to.	30. Name and address of mon who completed cause of death (Item 23a) (Type, Print)  Mohr Ncg 260) Veterant Hung, Millers vi  31. Date filed (Month, Day, Year)  OCT 18 2006  32. degistrar's Signature	ille, n	nd 2	1108
Sta Registr		OCT 1 8 2006 Been & American			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrat Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** October 1:35 PM Kathryn Joan Nixon /Medical 26,2006 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Lions Center Cumberland Allegany If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. Feb. 27, 1934 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, **Funeral** 9. Birthplace (State or Foreign 1 □ M 2 X F 214-32-3375 72 Director Maryland Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f ebov other traumatic event, the Medical Examinar must be redified at Director MD 1 Yes 2 No Garrett Grantsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10716 National Pike Completed by Funeral USA Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify 3 Widowed 4 □ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 12 should be filed within hand Mental Hygiene.
7 Is marked other than " College (1-4or 5+) Elementary/Secondary (0-12) Beautician Beauty Shop 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Sumame) Arthur Resh ပ Grace Yost 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 Department of Health a Important: If Item 27 Is any injury or other trains 000. P.O. Box 239, Salisbury, PA Donna J. Lichliter/Daughter 15558 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Grantsville Cemetery Oct. 29,2006 Grantsville, MD 4 □Donation 5 □ Other (Specify) 21. Signature of Funeral Service L 22. Name and Address of Facility Newman Funeral Homes, P.A. ensee P.O. Box 275, Grantsville, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart ailure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Metastatic **Physician** break aw year /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) sician and burial-transit certificate be executed Due to (or as a consequence of): Box 68760, the attending physician an/Medical as the esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year signed by the a 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No 24a. Was an autopsy performed 2 No 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one)

of Vital Records, director, 2 this Director: After the Certification: Division To the Hospitel or Attending death. after

2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident Injury 5 Pending 1 TYes 2 TNo investigation 3 🗌 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \( \text{Homicide} \)

29a. Certifier (Check only one) 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier salell MO

29c. License number

29d. Date signed (Month, Day, Year)

umberland, MD 21502

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) >haki l MD 625

2006

31. Date filed (Month, Day, Year) 3 0 OCT

32. Registrar's Signature

DHMH 17 Rev 1/2001

within 24 hours a To the Funerel C

Medical

State

Registrar

			For State Registrar	State of Maryla		artment of H			ene g. No. 2006	34910
100	40	g.	Decedent's Name (First, Middle, Last)					2. Date of Death	)	3. Time of Death
	Physici		James Igna	tius Owens				October	25, 2006	5:40 A M
	/Medic Examin		4a. Facility Name (If not institution, give s			4b. City, Town, or	Location of Death		4c. County of Death	
20			23411 Maypole Roa	.d		Leonar			St.Mary'	S
350	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs	s. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year) 9. Birth	place (State or Foreign ntry)
	Director		Usual Residence of Decedent	85_	TIS.			February 9	,1921 Mary	land
	land ow		10a. State 10b. County	10c. C	City, Town or Lo	ocation				10d. Inside City Limits
	Man a-1 sh	호	Maryland St. Mary	's	Leonard	ltown				1 ☐ Yes 2 💥 No
	th the	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of What Cou	ntry?
	23a c		23411 Maypole Road			20650	)		USA	
	teme	Funeral	TI Maria States	12. Was Decedent Ever in Armed Forces?		Was Decedent of His If Yes, specify Cubar	spanic Origin? (Sp n, Mexican, Puerto	pecify Yes or No- Rican, etc.)	14. Race - Ameri Black, White,	
36	rs afte	by F	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 X Yes 2 □ No If Yes, Give Year or Dates: 1942:	1045	1 ☐ Yes 2 ☒ No	Specify:		Specify: Whi	te
21215-0036	d within 72 hours after death with the Maryland jene. rr than "natural", or Iteme 23a or 28a-1 show the Medical Exactinat must be rectified at		15. Decedent's Educ	cation	16a. Dece	dent's Usual Occupa	ition	. 1	6b. Kind of Business/Ir	ndustry
215	hin 72 In "na	pie	(Specify only highest grade	College (1-4or 5+)	(Give	kind of work done d DO NOT use retired)	uring most of worl	king	II C . C	
2	77 75 75 75	Completed	8		P	Machinist			U.S. Gove	rment
nd	be filed ital Hygi d other event, it	Be	17. Father's Name (First, Middle, Last)					e (First, Middle, M		
yla	should by nd Menta marked umatic ev	ုင	William Owens					ine Russ		
Maryland	12 sho h and 7 le ma		19a. Informant's Name/Relationship (Type						City or Town, State, Zij	
	s 1 and 2 should be filed f Health and Mental Hyg Item 27 Is marked othe other traumatic event,		Michelle M. Owens/ 20a. Method of Disposition		Place of Dispo	sition (Name of		Date 2	n, Maryland 2 Oc. Location - City or T	
no	Pages nent of I		1 ☑ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)		•	matory`or other place	0ctob	er 30 2006	Bushwood, Mar	
Baltimore,	# tt = .		21. Signature of Funeral Service License			rt Cemetery 2. Name and Addres		2006	busiiwoou, mai	yland
Ã	Depa Impo any ii		Thickers Her	Hardine	1	iattingley-G 1590 Fenwic	ardiner Fu	neral Home	PA Maryland 206	550
			23a. Part1. Enter the disease, or compli- shock, or heart failure. List only on	cations that caused the de-	Do not ent	er the mode of dying	g, such as cardiac	or respiratory arre	e ustulke	Approximate Interval Between
1	Physician		Immediate Cause (Final disease or condition	Acousa	tim	· hui	nvenue	10		Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a conse	equence of):	10	1			
	Examine		Sequentially list conditions, b	1/16/2085	cure,	Ster part	hicale	Oleration	e	
	ed set	ulne	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or at a conse	equence or): /	V	10	auro pres	usulle_	
•	xecut and al-trar	Examiner	that initiated events cresulting in death) Last	Due to (or as a conse	equence of):			des	Elise	
8760,	icate be executed physician and s the burial-transit	dical E								
9	ifficating phy as the	edi								
Box	death certifica e attending pt od for use as t	N/UE	23b. Was decedent pregnant	3c. If yes, outcome of preg 1 ☐ Live birth 2 ☐ Fe		Ectopic pregnancy			23d. Date of deliv	•
		sicis	in the past 12 months? 1 Yes 2 No	4☐Pregnant at time of		Other (specify)	· · · · · · · · · · · · · · · · · · ·		Month	Day Year
P.0	law requires that the de as been signed by the a 2 should be detached t	Physician/Me	9 ☐ Unknown  Part II. Other significant conditions con				- in Post	22a Did tab	acco use contribute to t	be seened of death?
	ires tha signed d be de	þ	1 0 1 1	Inullar Ds	sulling in the d	o Dolla	min Parti.		s 2 No 3 Pro	\/
Ö	w requir been si should	etec	prigate or the	Ur con Capp	1-23	- Juni	morece			, ,
Vital Records,	o _ c @	ompleted						24a. Was an autopsy perform	prior to co	opsy findings available impletion of cause of
al	icien: Th certificate rector, pag	e Co	25. Was case referred to medical				00 Blood B	1□ Yes 2	No 1 □ Yes	2□ No
		o B	examiner?	ospital: 1 ☐ Inpatient 2	☐ ER/Outpatier	nt 3 DOA Othe	r	th (Check only one	nce 6 Other (Speci	6/1
10	g Physer this seral di	Ë	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time o			28d. Describe ho		
joi	Attending r death. ector: After by the fune	atio	1 ✓ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day 1 dar)	injury		res 2□No			
Division	or Atterder de Director in by the	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At building, etc. (Spec	home, farm, str	reet, factory, office		28f. Location (Str. City or Town,	eet and Number or Run State)	al Route Number,
Ω	lospitel of hours af uneral D								<del></del>	
	T 4 T 2	edical	29a. Certifier Certifying Phys (Check only one) 2 Madical Examir	sician: To the best of my kiner: On the basis of examinand manner stated.	nowledge, deat nation and/or in	h occurred at the tim vestigation, in my op	e, date and place, inion, death occur	and due to the car red at the time, da	use(s) and manner as s te and place, and due t	stated. o the cause(s)
/	To the vithin 2 To the complex	Me	29b. Signature and title of certifier	and marinor stated.	1	29c. License	number	29	d. Date signed (Month,	Day, Year)
	->-0		~ 1, 1, 2°		1	()9	1500		10.26-01	6
•			30. Name and address of person who co	mpleted cause of death (Ite	эт 23а) (Туре,	Print)				
				Mary's Yetar		/ Monardtown,	MD 20650	- a- w		
200	Sta		OCT 2 7 2005	32. Registrar's Sign	nature					
	Registi	al	2012 1 2000	way Xr Ago						

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				State of Mar s 28a-f per	yland / Dep <b>ME,G861</b> <sub>0</sub>	artment of	Health and <b>B</b> eath		giene eg. N.20	06	34911
****	Physic /Medi		1. Decedent's Name (First, Middle, La Robert Earl	Pumphrey,	Jr., MD			2. Date of Dea Month Oct. 18	Day	Year	3. Time of Death 5:00 P M
į.	Examir		4a. Facility Name (If not institution, giv	e street and number)		4b. City, Town,	or Location of Dea		4c. County	of Death	3.00 1
	*		1579 Shoreline D	rive		Sw	anton		Gar	rett	
	Funeral Director		203-30-1099	MA SDE	n yrs. last birthday	Months Days			, Year)	9. Birthp Coun Ohio	
	land w		Usual Residence of Decedent  10a. State 10b. County	1	0c. City, Town or L	ocation				1	Od. Inside City Limits
	Marylan -f show lied at	ğ	MD Montgo	nerv		Bethesd	a				1 X Yes 2 □ No
	h the	Director	10e. Street and Number			10f. Zip Code	7.0	1	0g. Citizen of \	What Coun	try?
	th wit		8217 Burning Tre	e Road			20817		U	SA	
980	be filed within 72 hours after death with the Maryland tal Hygiene. Id other than "natural", or Iteme 23a or 28a-f show event, Ira Medical Exactivar marks the recitified at	by Funeral	11. Marital Status  1 ☐ Never Married 2 📆 Married  3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Eve Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates: V		Was Decedent of If Yes, specify Cul		Specify Yes or No- to Rican, etc.)	14. Rac Blac Specify	e - Americ ck, White, e	
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Man	カドトー		19a. Informant's Name/Relationship ( Lisa R. Humphrey)					ural Route Number			
	Pages 1 and nent of Heath int: If Item 2 iry or other		20a. Method of Disposition 1 □ Burial 2 ☒ Cremation 3 □		20b. Place of Dispo cemetery, cre	osition (Name of matory or other pla	ace)	Date	20c. Location -	City or To	wn, State
Baltimore,	permit. Pages Department of t tmportant: If It eny injury or or once.		4 □ Donation 5 □ Other (Specification of Fundral Service □ Servic			2. Name and Addr	ess of Facility	32 S.	Morgant Second	St.	
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H	Physician /Medical		shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	one cause on each line.	by suffo			oor roophatory and		M	Interval Between Onset and Death Inutes
8760,	ate be executed shysicien and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Oue to (or as a co							
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rds, P	w requires that the been signed by th should be detache	ρ	Part II. Other significant conditions of	ontributing to death but n	ot resulting in the u	nderlying cause gr	ven in Part I.				e cause of death?
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Ž	\$	2	Yes 2□ No	Hospital: 1 ☐ Inpatient	2 ER/Outpatier	nt 3□ DOA Ot	her: 4 🗆 Nursing H	lome 5 Reside	nce 6 Oth	er (Specify)	)
	Jing After fune		27. Manner of Death  1 Natural 5 Pending investigation	1111/1×//1##	ear) 28b. Time o	f 28c. Inju	nyat ork? ]Yes 2 <b>•€</b> No	28d. Describe ho	w injury occurred	ed	astic bag
Division	- E E	Certification:	Suicide 6 ☐ Could not be determined	28e. Place of Injury building, etc. (S Summer	- At home, farm, str Specify)	reet, factory, office		28f. Location (St. 1579 Sho) Swanton	reline	or Rural <b>Driv</b> e	Route Number,
	To the Hospital or within 24 hours af To the Funeral D completely filled in	edical	29a. Certifier (Check only one)  1 ☐ Certifying Ph 2 Medical Exam	ysician: To the best of m niner: On the basis of ex and manner stated	amination and/or in	h occurred at the to vestigation, in my	me, date and place opinion, death occ	a, and due to the ca	use(s) and ma	nner as sta and due to	ited. the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier			29c. Licen	se number	25	9d. Date signed	(Month, D	Day, Year)
}			Paul Daniel	melle 7	80	H2	6154		101	19	106
			30. Name and address of person who			•			-	*	
3.5	- 500 m		Dr. P. Daniel Mil 31. Date filed (Month, Day, Year)	ler, DO 1	86 Thornb	erry Roa	d, Oakla	nd, Maryl	and 21	550	
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Maryland f show	ō	10a. State	10b. County		10c. City, Town		ocation					10d. Inside Cit	
the N	Director	MD 10e. Street and Nu	Cecil mber		E1kt	on	10f. Zip Code			10g. Cit	izen of What C	ountry?	
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permit. Pages 1 and 2 should be filed within 72 hours atter death with the Maryland Department of Health and Mental Hygiene Important: If item 27 is marked other than "natural", or items 23e or 28e-f show any niury or other traumatic event, Ire Modical Exercities is at the multiple of and once.	by Funerai	11. Marital Status  1 Never Marr 3 Widowed	ied 2⊠ Married 4 □ Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2 🕱! If Yes, Give Year or Dates:			Was Decedent of His If Yes, specify Cubar 1 ☐ Yes 2 ☑ No	spanic Origin? ( n, Mexican, Pue Specify:	Specify Yes or No rto Rican, etc.)	wh	14. Race - Am Black, Whi		
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IVICALLY IN 2 Shoulth and M Ith and M 27 Is man			ame/Relationship (				ng Address (Street a		Rural Route Number		or Town, State,	Zip Code)	
s 1 an f Heal itam 2		20a. Method of Dis	•	-	20b. Place of I	Dispo	osition (Name of matory or other place	- 4	Date	20c. L	ocation - City or	Town, State	
Page nent o int: If			☐ Cremation 3 ☐ 5 ☐ Other (Specif	Removal from State y)			nts Cem.		.19,2006	V	Vilming:	ton, DE	
permit. Departing Imports any injuice.		21. Signature of Fi	uneral Service Lie	) 00	100	22	2. Name and Addres	· P	CCrery F			es, Inc.	
		23a. Part L. Enter I	the disease, or com art failure. List only	plications that caused one cause on each li	the death. Do no	ot ent	3924 Cond ter the mode of dying				19803	Approximate Interval Betw	yeen
Physician		Immediate Cause disease or condition	(Final	2	Deme	40	,					Oncot and D	laath
/Medical Examiner		resulting in death)		Due to (or as	a consequence of	f):						Unknow	
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ysician: The law is certificate has be director, page 2 s	Completed								24a. Was autor perfo 1 \( \text{Yes}		prior to death?	utopsy findings a completion of ca s 2 \(\sum \) No	vailable luse of
vital sician: certifical rector, p	Be	25. Was case refe examiner?		Hospital:			Othe		eath (Check only o				
a E B	ion: To	1 Yes 2 2.  27. Manner of Dea 1 Natural	th 5 Pending	28a. Date of Inju (Month, Da	ıry 28b. Ti	,	f 28c. Injury Work	at ?	Home 5 Residence			ecify)	
To the Hospital or Attanding Physicien: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director.	Certification:	2 Accident 3 Suicide 4 Homicide	investigatio 6  Could not b determined	e 28e. Place of Inj	iury - At home, fan c. (Specify)	m, sti	M 1 1 1	∕es 2 □ No	28f. Location (: City or To			lural Route Numb	рө <i>г</i> ,
Mospita 24 hours Funaral stely filled	edical C	29a. Certifier (Check only one)	1 Certifying Pt 2 Medical Exa	nysicien: To the best miner: On the basis o and manner st	it examination and	, deat Vor in	th occurred at the time operation, in my op	e, date and place pinion, death occ	ce, and due to the curred at the time,	cause(s date an	) and manner a d place, and du	s stated. e to the cause(s)	
Fo tha vithin Fo tha	Med	29b. Signature and	tipe of certifier	and marrier at		_	29c. License	number		29d. Da	te signed (Mon	th, Day, Year)	
F > F 0		> /	Jackdo.	15 mD			2002	3322			10.16.	2006	
6		30. Name and add	ress of person who	completed cause of c	leath (Item 23a) (1	Type,	Print) Sub 3B	, Es	Ch Ton M	08	21921		
St Regist	ate rar	31. Date filed (Mo	onth, Day, Year) CT 1.9 20	completed cause of c	rar's Signature	do	selv .	1 -					
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Registrar DHMH 17 Rev 1/2001

			1- State of Maryland / Department of Health and Negistrar Amend Items 16a, b, 23a, PtI, II per FH/Dr C861, 11	/lental Hyd /16/06dl	piene nb 2006	34913
	Physici	an	Decedent's Name (First, Middle, Last)	2. Date of Dea Month		3. Time of Death
	/Medi		Emily Duvon Pittman	Oct. 2	2, 2006	12:35 A <sup>M</sup>
	Examir	er	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 3296 Fingerboard Road Oakland		4c. County of Death	
	Funanci	-	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	8. Date of Birth	Garrett	des (Christian Carrier
L	Funeral Director		213-64-7547 1 M 2X F 52 Yrs. Months Days Hours Min.	(Month, Day 10/20/1	, Year) Cour	place (State or Foreign htry)
	pu ,		Usual Residence of Decedent	10/20/1		
	shoved	'n	10a. State 10b. County 10c. City, Town or Location		1	0d. Inside City Limits 1 ☐ Yes 2X No
	the A	Director	AZ Cochise Benson  10e. Street and Number 10f. Zip Code		0g. Citizen of What Cour	
	3a or	0	547 South J Six Ranch Road 85602		USA	itry r
	death	Funerai	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispanic Origin? (Sp. 14 f Yes, specify Cuban, Mexican, Puerte	ecify Yes or No-	14. Race - Americ	
98	or Ita		1 Never Married 2 Married 1 Yes 2 No	Hican, etc.)	Black, White,	
Ö	within 72 hours after death with the Maryland ene. than "natural", or itams 23a or 28e-f show tha Madical Examiner must be notified at	d by	3 Wildowed 4 Divorced Year or Dates:			nite —————
7	in 72 naf	ojete	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during most of work    life, DO NOT use retired	king	16b. Kind of Business/Ind	dustry
212	e filed within al Hygiene. I other than "	Completed	Elementary/Secondary (0-12)  College (1-4or 5+)  Legal Secretary  Sales Associate		US Governme	nt Law Fire
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yla	2 should be and Mental is marked craumatic even	To	Earl Hamilton Kitzmiller Ine	z Du	von Har	vey
lar	dand and rism		19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rus			Code)
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should Department of Health and Men Important: If tiem 27 is marke any injury or other traumatic <u>once</u> .		Johnny M. Pittman/ Husband 547 South J Six Ranch  20a. Method of Disposition (Name of		enson, AZ 8 20c. Location - City or To	5602
100	ages int of t: If Its		1X Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place)			
#	nit. P artme ortan injur.		21. Signature of Funeral Service Licensee 22. Name and Address of Facility	26/06	Oakland, MI Second St.	)
ä	Departiment of the poor of the		Stewart Funeral Ho	me Oakla	nd, MD 215	50
8760,	Physician /Medical Examiner but site private and private street street street but street	dicai Examiner	23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):		9	Approximate Internal Between Onset and Peath Internal Between Onset and Peath Internal Peath Int
.O. Box 6	The law requires that the death certificate ate has been signed by the attending phy bage 2 should be detached for use as the	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown  23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)		23d. Date of delive Month	ry Day Year
Records, P.	w requires tha been signed I should be det	þ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  Chronic Myelogenous Leukemia	23e. Did tob	pacco use contribute to the	e cause of death? ably 4 Unknown
al Reco	raician: The law r s certificate has be lirector, page 2 sh	Completed	,	24a. Was an autops perform	y prior to con ned? death?	osy findings available inpletion of cause of
Vital	ician certifi rector	Be	25. Was case referred to medical examiner?  Hospital:	h (Check only on	Θ)	
	Phys r this ral dii	T. To	1 Inpatient 2 EH/Outpatient 3 DOA 4 Nursing Ho		ince 6 Other (Specify w injury occurred	)
0	ding th. : Afte	itior	27. Manner of Death  1 Natural 5 Pending 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Work? 1 Yes 2 No	200. Describe no	w injury occurred	
Division of	al or Attendi s after death. Il Director: A id in by the fu	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (St. City or Town	reet and Number or Rural i, State)	Route Number,
	To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: Atter this certificate ha completely filled in by the funeral director, page	Medical	29a. Certifier (Check only one)  1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and manner stated.	and due to the ca	ause(s) and manner as state and place, and due to	ated. the cause(s)
	To T To 1	Σ	29b. Signature and title of certifier 29c. License number	25	ed. Date signed (Month, E	Dey, Year)
•			Knot Ashunk MD D2+209	)	10/20/0	06
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Karl Schwalm,  311 N. FOURTH ST. OKKLAND A	MD.	21550	
	Sta		31. Date filed (Monts, Day, Year) 2006 32. Registrar's Signature		x/300	
	Registr	77	The state of the s			

In Pierce 06-07133

Please Type or Print in Black Indelible Ink UNK UNK State of Maryland / Department of Health and Mental Hygiene 1. For State Certificate of Death Reg No Registrar Oecedent's Name (First, Middle,Last) 2 Date of Oeath Physician/ Month Oay Year September 21, 2006 **Medical Examiner** 1145 hrs Pierce John 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Oeath 4c. County of Oeath 45 North Gude Drive Rockville Montgomery 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8 Oate of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** Foreign Director 272-50-4093 10/12/1964 1 X M 41 Country) Michigan 2 F Usual Residence of Decedent 10a. State 10c. City. Town or Location 10d Inside City Limits 1 X Yes 2 No or 28a-f show itenis 23a or 28a-f shovust be notified at once. Massillon Ohio Stark Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country 1341 Huron Road SE 44646 United States Funeral 11. Marital Status 12. Was Oecedent Ever in U.S. 13. Was Oecedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 X Never Married 2 Married Yes 2 X No 3 Widowed 4 Divorced Yes, Give Year 1 Yes 2 X No specify: ages I and 2 should be filed within 72 hours after in of Health and Mental Hygiene.
It: If item 27 is marked other than "natural", other traumatic event, the Medical Examiner. SpecifyAfrican-American þ r Dates 15 Oecedent's Education (Specify only highest grade completed) 16a. Oecedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. OO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) Baltimore, MD 21215-0036 pernit Pages I and 2 should be filed within 72 h Department of Health and Mental Hygiene 2 Machine Technician Factory 17. Father's Name (First, Middle, Last) 18 Mother's Name (First, Middle, Maiden Surname) Be Willie C. Pierce Barbara Adams 19a Informant's Name/Relationship (Type, Print) ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Pierce / Sister 804 Gallop Hill Road #T-1; Gaithersburg, MD 20879 20a. Method of Oisposition 20b. Place of Oisposition (Name of cemetery, Date 20c. Location - City or Town, State crematory or other place) 1 Burial 2 Cremation 3 Removal from State 10/19/06 Department of Important: I 10/19/2006Lincoln Crematory Brentwood, Maryland Oonation 5 Other Specify 21. Signature of Fundral Service Licensee 22. Name and Address of Facility
Simple Tribute Funeral and Cremation Center 1040 Rockville Pike; Rockville, Maryland 20852 I. Enter the disease, o complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Approximate Interval failure. List only one cause on each line. Between Onset and /Medical a. Hanging Death Immediate Cause (Final disease Examiner or condition resulting in death) Oue to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Examine Oue to (or as a consequence of) (Oisease or injury that initiated Oue to (or as a consequence of) events resulting in death) Last and Physician/Medical UNPENOEO #19bperfH10/19/06,BWM.MoCo ending physician use as the burial Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c If yes, outcome of pregnancy 23d. Date of delivery 23b Was decedent pregnant in the Live birth Fetal death 3 Ectopic pregnancy Day Year past 12 months? 2 Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Yes 2 ✓ No 3 Probably 4 Unknown Completed 24a Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? Yes 2 1 🗸 Yes 25 Was case referred to medical 26.Place of Oeath (Check only one) Be examiner? Other<sub>4</sub> Inpatient ER/Outpatient 3 DOA Nursing Home 5 Residence 6 V Other Scene 1 V Yes 28a. Date of Injury FOUND: Day, Year) 27. Manner of Oeath 2Bb. Time of Injury 28d. Oescribe how injury occurred 2Bc. Injury at Work? Certification Subject hanged self FOUND. Naturai 5 Pending 1 Yes 2 V No Sep 21, 2006 1130 hrs Accident Investigation 28e Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 V Suicide Could not be (Specify) Woods 45 North Gude Drive, Rockville, Md. Homicide 29a. Certifier 1 (Check only one) 2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started Medical 2 😿 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29d Oate signed (Month, Day, Year) O.C.M.E. September 22, 2006 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Carol Allan, MD Assistant Medical Examiner

State Registrar

31. Oate filed (Month, Day, Year,

32 Registrar's Signaty

2006

		For State	State of Maryland	-	rtment of H			2000	34915
		Registrar  1. Decedent's Name (First, Middle, Last)		0011	incate of L		2. Date of Death	g. No.	3. Time of Death
Physicia /Medic		Walter D	Prather				October .	Day Year	11100 011
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Funeral		5. Social Security Number 6. Sex	toluentist Hosp 7. Age (In yrs. ids	t birthday)	Kockv If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	Montgo 8. Birt	thplace (State or Foreign
Director		213 30 3202	X <sup>M 2□ F</sup> 63	Yrs.	Months Days	Hours Min.	Oct. 29	,1942 M	aryland
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r 28a	Director	10e. Street and Number		<u></u>	10f. Zip Code		10	g. Citizen of What Co	Juntry?
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deat	Funeral	11. Maritat Status	12. Was Decedent Ever in U.S. Armed Forces?	13. W	/as Decedent of His Yes, specify Cubar	spanic Origin? (Sp	ecify Yes or No-	14. Race - Ame Black, Whit	
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2 hour		15. Decedent's Edu	cation		ent's Usual Occupa		1	6b. Kind of Business	Industry
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and 2 s ealth an m 27 io	H	Beverly Prathe						ille,MD	
) - i = =		20a. Method of Disposition	20b. Plac	e of Dispos	ition (Name of atory or other place		-	0c. Location - City or	
Peges nent of int: If its iry or o		t	emoval from State	-			19/06	Rockvill	e. MD
D		21. Signature of Funeral Service Licens		22.	Name and Addres	s of Facility SN	OWDEN F	UNERAL H	OME, P.A.
M #9 = # 9		Ceange	Sudden						,MD 20850
		23a. Part1. Enter the disease, or complishock, or heart failure. List only or	cations that caused the death. le cause on each line.	Do not ente	r the mode of dying	, such as cardiac	or respiratory arre	st,	Approximate Interval Between Onset and Death
Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Preumoni	_					Ships, and Double
Examiner			Due to (or as a consequer	nce of):					
	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initial property)	Due to (or as a consequen	nce of):					
be executed sicien and burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last							
be exe		resolving in deadily cast	Due to (or as a conseque	nce of):					
the type	edical								
eath certific ettending p	M/I	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pregnance					23d. Oate of de	livery
death	Physician/Me	in the past 12 months? 1 □Yes 2 □ No	1 ☐ Live birth 2 ☐ Fetal de 4 ☐ Pregnant at time of deal 9 ☐ Unknown		Ectopic pregnancy Other (specify)			Month	Day Year
that the de ed by the e	Phy	9 Unknown				3. <b></b>	02- 014-5		
sign d be	d by	Part II. Other significant conditions cor	tributing to death but not result	ng in the un	derlying cause give	in in Part I.	1/4	accoluse contribute to s 2 □ No 3 □ Pi	robably 4 Dunknown
w requ	lete						24a. Was an		utopsy findings available
The lavente has page 2	Completed						autopsy perform 1 Yes 2	ed2 prior to death?	completion of cause of
	BeC	25. Was case referred to medical				26. Place of Deal	h (Check only one		210140
<u> </u>	To	examiner? 1 Yes 2 No	ospital: 1 Impatient 2 EF	VOutpatient	3□ DOA Othe	or: 4 🗌 Nursing Ho	ome 5 🗆 Resider	nce 6 Other (Spe	cify)
- p = e	on	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	8b. Time of Injury	28c. Injury Work		28d. Describe how	w injury occurred	
Attending or death.	lcat	2 Accident investigation 3 Suicide 6 Could not be	28e Place of Injury - At hom	e farm stre		/es 2 □ No	28f Location /Str.	eet and Number or R	ural Pouta Number
after Direction by	Certification:	4 Homicide determined	28e. Place of Injury - At hom building, etc. (Specify)	o, tarrit, stre	et, factory, office		City or Town,		nai Addio Ngmber,
To the Hospital or Attendii within 24 hours after death. To the Funerel Director: A completely filled in by the fu	edical C	(Check only 2 Medical Exami:	sician: To the best of my knowle ser: On the basis of examination	edge, death	occurred at the time	e, date and place,	and due to the car	use(s) and manner as	s stated.
rothe Pivithin 24 Fo the Foundlet	Med	one) 29b. Signature and title of certifier	and manner stated.						` '
		1 Kardy 21	MD		hon	1.41020		10/11/01	
V		30. Name and address of person who co	mpteted cause of death (Item 2	3a) (Type, I	Print)	10 L7		10/11/06	,
F-27		Brandon Falk	9901 Medica	1 Cen	ter Driv	ie Ro	ckville,	Marylana	1
Sta Registr		31. Date filed (Month, Day, Year)	mpleted cause of death (Item 2 9701 Medical 32 Registrar's Signatur	900	of i			/	
gio(i		111:1 TO 50	- PUTTERY MAN						

DHMH 17 Rev 1/2001

Registrar

OCT

			1 - For State Registrar	State of Ma	aryland / Depa <i>Cei</i>	artment of H			iene 006	34917
			1. Decedent's Name (First, Middle, Last	)				2. Date of Deat	th	3. Time of Death
	Physici /Medio		Paul Edward Puska	r				Oct.	20 <sup>°ay</sup> 20°0	6 10:45A M
	Examin		4a. Facility Name (If not institution, give 15943B Broadfordi			4b. City, Town, or Hagers	Location of Death		4c. County of D. Washi	ngton
Ī	Funeral Director		5. Social Security Number 6. Se 187–34–2606	x 7. Ag ¶M 2□F	e (In yrs. last birthday) 63 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year)	Birthplace (State or Foreign Country)
			Usual Residence of Decedent					12/05/1	.942	PA
	rylan		10a. State 10b. County		10c. City, Town or Lo					10d. Inside City Limits
	8a-f a	cto	MD Washing	ton	Hager					1 ☐ Yes 2 ☑ No
	th with the 23a or 2 ust be n	Funeral Director	10e. Street and Number 15943B Broadfordi	ng Road		10f. Zip Code 21740	)	1	0g. Citizen of What US	Country?
21215-0036	72 hours after death with the Maryland natural', or Items 23a or 28a-f show acat Examiner oust be mailited at		11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2 🛣 If If Yes, Give Year or Dates:	10	Was Decedent of Hi f Yes, specify Cuba i ☐ Yes 2점 No	ispanic Origin? (Sp in, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - A Black, W Specify:	merican Indian, hite, etc. White
2-0	"natural",	eted	15. Decedent's Edu (Specify only highest grad		(Give	lent's Usual Occupa	during most of work	ina	16b. Kind of Busine	ss/Industry
121		Completed by	Elementary/Secondary (0-12)	College (1-4or 5	i+) life. L	oo not use retired tail Mana	)		Auto R	acina
d 2	illed withir I Hygiene. other then		17. Father's Name (First, Middle, Last)		, NE	tall rana	18. Mother's Name	e (First, Middle, M		acing
/lan		To Be	John Paul Puskar				Ann Mar	ie Chval	a	
Maryland	nd 2 sho lith and 27 Is m		19a. Informant's Name/Relationship (7) Patsy Crumbacker		19b. Mailin 159	g Address (Street a	and Number or Run lfording l	al Route Number, Road, Ha	. City or Town, State gerstown,	MD 21740
Baltimore,	o o		20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ F			natory or other plac	θ)		20c. Location - City	
Ħ			<ul><li>4 □ Donation 5 □ Other (Specify)</li><li>21. Signature of Funeral Service Licens</li></ul>		Greenlawn				Williamsp	ort, MD uneral Home
Ba	permit. Departn Importe any inju		1327	1					erstown,	
	Physician		23a. Part1. Enter the disease, or comp shock, or heart failure. List only o Immediate Cause (Final	ne cause on each lir	the death. Do not entered.				est,	Approximate Interval Between Onset and Death
	/Medical Examiner		disease or condition resulting in death)	a	a consequence of):		<b>,</b>			८ विस्तुन्तु
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury	Due to (or as	a consequence of):					
	ecuted and -transi	Examine	Cause (Diseese or injury that initiated events resulting in death) Last	Due to /or on	a consequence of):					
8760,	cate be executed physician and the burial-transit	dicai E		d.	a consequence or,					
Ψ	ntificat ng phy as th		IF FEMALE.							
.O. Box	it the death certifi by the attending I tached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of o Month	delivery Day Year
<u>α</u>	The law requires that the site has been signed by the bage 2 should be detached.	þ	Part II. Other significent conditions co	ntributing to death b	ut not resulting in the ur	nderlying cause give	en in Part I.	23e. Did tob		to the cause of death?  Probably 4 Unknown
of Vital Records,	The law reate has bee	Completed						24a. Was ar autops perform	y prior t	
/ita	sicien: certifica irector, p	Be	25. Was case referred to medical examiner?				26. Place of Death		9)	
of/	S S	안	1 ☐ Yes 2 ☑ No  27. Manner of Death	lospital: 1 ☐ Inpatie			4 🔲 Nursing no		nce 6 Other (S)	oecify)
ono	ding h. After fune	tion	1 Natural 5 ☐ Pending	28a. Date of Injui (Month, Da)	y Year) 28b. Time of Injury	28c, Injury Work	rat ⟨? /es 2 □ No	280. Describe no	w injury occurred	
Division	l or Attending after death. Director: After I in by the funer	Certification;	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injubulding, etc	ury - At home, farm, stre			28f. Location (Str City or Town	reet and Number or , State)	Rural Route Number,
_	Hospita 4 hours Funerel ely fillec	edical C	29a. Certifier (Check only one)  Certifying Phy Medicel Exami	sician: To the best oner: On the basis of and manner sta	of my knowledge, death examination and/or invited.	occurred at the timestigation, in my op	ie, date and place, pinion, death occurr	and due to the ca	use(s) and manner ite and place, and d	as stated. ue to the cause(s)
i	To the twithin 2: To the I	Me	29b. Signature and Jiffe of certifier	O Com	2, as	29c. License	31761	29	ed. Date signed (Mg	nth, Day, Year)
5 H	1-10		30. Name and address of person who co	empleted cause of de	eath (Item 23a) (Type, I	Print) SEVER	TH STE.	FREDE	RICK M	4A 21761
	Sta Registr		31. Date filed (Month, Day, Year) OCT 2 3 20	32. Registra	ar's Signature	et l			<del>,</del>	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 10 ĩ'8 06 8:00 am Abdul Qayum Oazi /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Kensington Montgomery Kensington Nursing Home If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days 1 XM 2 □ F 71 230-17-0524 3/17/1935 Pakistan Usual Residence of Decedent pelmit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" any injury or other traumatic everal. 10a State 10c. City, Town or Location 10d. Inside City Limits VA McLean 1 ☐ Yes 2 XNo Director Fairfax 10f, Zip Code 10g. Citizen of What Country? 10e Street and Number 22101 Pakistan 1602 Dunterry Place Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11 Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 X No Specify: Specify: white þ 3 Widowed 4 Divorced Be Completed | 16a Decedent's Usual Occupation 16h Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Accountant Accounting 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Abdul Wahab Shireen 0aziBegum ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1602 Dunterry Place, McLean, VA 22101 Sabiha Qayum/ wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Family Cemetery 10/23/06 Peshawar, Pakistan 4 Donation 5 Dother (Special 22. Name and Address of Facility Universal Mortuary 21. Signatu of Fineral Service Lice 411 Kennedy St., N.W. Washington, DC 20011 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Atherosclerotic Heart Disease years Due to (or as a consequence of) Hypertension years Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Duy to (or an a consequence of) Examiner Diabetes years Due to (or as a consequence of): Physician/Medical IF FEMALE Be Completed by Medical Certification: To

/Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed burial-tra Division or Vital Records, P.O. Box 68760, ate has been sign page 2 should be within 24 hours after death To the Funeral Director: filled in by

**Physician** 

**Funeral** 

Director

23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome pf pregnt  1 □ Live birth 2 □ Feta  4 □ Pregnant at time of o  9 □ Unknown	ıl déath 3⊒Ectopid	c pregnancy (specify)		23d. Date of delivery Month Day Year	
Part II. Other significant conditions co	ontributing to death but not res	ulting in the underlyin	g cause given in Part I.	23e. Did tobac	cco use contribute to the cause of death	?
End Stage Rena	al Disease,	Chronic	Leg Ulcer	1 ☐ Yes	2 No 3 Probably 4 Maunh	own
				24a. Was an autopsy pertorme 1 <b>⋉</b> Yes 2 [		able of
25. Was case referred to medical			26. Place of De	ath (Check only one)		
examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3	DOA Other: 4 Nursing	Home 5 ☐ Residence	ce 6 □Other (Specify)	
27. Manner of Death 1 T\natural 5 □ Pending 2 □ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how	injury occurred	
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At he building, etc. (Special	ome, farm, street, fac fy)	tory, office	28f. Location (Stree City or Town,	et and Number or Rural Route Number, State)	
	ysician: To the best of my kno niner: On the basis of examina and manner stated.				se(s) and manner as stated. e and place, and due to the cause(s)	
COL Cinneton and title of an differ			20c License number	204	Data signed (Month Day Vear)	

State Registrar

completely

10301 Georgia Ave. SilverSpring, Maryland 20902 Anuradha

12006

31. Date filed (Month, Day, Year)

19

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
AMEND TTEM#21 perFH C861 11/2/06 WS
State of Maryland / Department of Health and Mental Hygien@ () () 6

34919 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2006 **Physician** 19, Oct. 11:58P M Wilma Agnes Rembold /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Garrett County Mem'l Hospital Oakland Garrett | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | (Month, Day, Year) | 0 7 / 1 8 / 1 9 1 4 7. Age (In yrs. last birthday) 92 yrs. 9. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** 1 □ M 2 🗗 F 232-86-2625 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: if item 27 is marked other then "natural", or Items 23a or 28a-f show eny injury or other treumatic event, the Medical Evantment must be routiled at engine. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1X Yes 2 □ No Director Preston Aurora 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Rural Route 1 Box 205 26705 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2X☐ No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify: Specify: White Completed by If Yes, Give Year or Dates: 3

Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Housewife Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James Walter Feather Estella Agnes Harsh 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) RR1 Box 5A Aurora, WV 26705 Sandie Kisner Date 20a. Method of Disposition 20b. Place of Disposition (Name of Marenese) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 1 4 ☐ Donation 5 ☐ Other (Specify) 10/25/06 Eclon, WV Cemetery 21. Signature of Funeral Service Licensee Hinkle Funeral Home Lester R. Hinkle PER DVR P.O. Box 186 Davis, WV 26260 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Acute Myocardial Infarction disease or condition resulting in death) immediate /Medical Due to (or as a consequence of) Examiner Atherosclerotic Heart Disease years Sequentially list conditions, if any, bearing to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner physician and s the burial-transit To the Hospitel or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 1 🗌 Yes 2 ER/Outpatient 3 DOA Inpatient filled in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Director: After 5 Pending investigation atural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 🗌 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funerel I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a Certifier and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) who completed cause of death (Item 23a) (Type, Print) akland MD. John pson 32. Registrar's Signature State Registrar

		•	State of Maryland / Dep	eartment of Health and Nertificate of Death	lental Hygie	71116	34920
	° Physici	an	1. Decedent's Name (First, Middle, Last)  Jeane Patricia Ross		2. Date of Death Month October 1	8°, 2006	3. Time of Death  2:45p M
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	DOCCOBOL 1	4c. County of Death	-1
			Genesis Healthcare  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Severna Park    If Under 1 Year   If Under 24 Hrs.	8. Date of Birth	Anne A	
	Funeral Director		218–26–3747  1 M 2 X F 75 Yrs.	Months Days Hours Min.	(Month, Day, Ye	1931 Ma	place (State or Foreign intry) ryland
	land w		Usual Residence of Decedent           10a. State         10b. County         10c. City, Town or I.	ocation			10d. Inside City Limits
	e Mary 3a-f sh	ctor	MD Anne Arundel Severn	a Park			1 □ Yes 2 No
	with th	i Dire	10e. Street and Number 39 Kleis Road	10f. Zip Code 21146	10g.	Citizen of What Cou USA	ntry?
	ams 23	Funeral Director		. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ameri Black, White	
39	72 hours after death with the Maryland naturel', or Items 23a or 28a-f show areal Examiner must be notified at	by Fu	1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	1 ☐ Yes 2 ☑ No Specify:			nite
Maryland 21215-0036	72 hou		(Specify only highest grade completed) (Giv	edent's Usual Occupation e kind of work done during most of work		o. Kind of Business/Ir	ndustry
2121	d within piene. r than	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	DO NOT use retired)  Homemaker		Home	
nd	be filec tal Hyg d otha avent,	Be	17. Father's Name (First, Middle, Last)	18. Mother's Nam	e (First, Middle, Mai		
ıryla	should nd Men marke matic	은	Thomas A. Rowan  19a. Informant's Name/Relationship (Type, Print)  19b. Mai	ling Address (Street and Number or Rus	Ellen Morn		p Code)
ĭ, Ma	and 2 : ealth ar n 27 is ear trau				erna Park,		
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel", or Items 23a or 28a-f show any injury or other traumatic avent, the Medical Examined must be notified at ances.			ans Cemetery Octo	ber 20,	c. Location - City or T Crownsville	
Baltir	permit. F Departme Importan any injur		21 Signature of Funeral Service Licens	22. Name and Address of Facility Barranco & Sons, P	A. Seve	rna Park I	Funeral Home
_	205 29	4	23a, art. Enter the disease, or complications that caused the death. Do not enshock or heart failure. List only one cause on e. ch. line.	495 Gov. Ritchie H	lwy. Seve	rna Park,	MD 21146 Approximate
1	Physician	1	shock or heart failure. List only one cause on e.ch line. Immediat Cause (Final disease or condition	er's deme	ntia		Interval Between Onset and Death
	/Medical Examiner		resulting in death)  Due to (or as a consequence of):	0, 0, 0, 0			U
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause United thins.				
	be executed sician and burial-transit	Examine	Cause (Disease or Injury) that initiated events resulting in death) Last  Due to (or as a consequence of):				
8760,	ate be executed hysician and the burial-transit	dical E	d				
9		a a	IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of deliv	/erv
Box (	atte	Physician/M	1 Yes 2 No 4 Pregnant at time of death 5	☐ Ectopic pregnancy ☐ Other (specify)		Month	Day Year
P.O.	that the de led by the a detached		9 ☐ Unknown  Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobac	co use contribute to	the cause of death?
rds	w requires been sign should be	ed by			1 ☐ Yes	2 □No 3 □ Pro	bably 4 binknown
Vital Records,	e law re has be je 2 sho	omplet		<del>-</del>	24a. Was an autopsy performed	24b. Were autoprior to co	opsy findings available ompletion of cause of
tal		e C	25. Was case referred to predical	26. Place of Dea	1 ☐ Yes 2 ☑ th (Check only one)		2 No
of V	Physic this ce al direc	ToB	examiner?  1 Yes 2 INo  Hospital:  1 Inpatient 2 ER/Outpatient  27. Manner Death  28a. Date of Injury  28b. Time	- Internation -	ome 5 Residence	e 6 Other (Speci	fy)
ion	fter nei	atlon	27. Manner a Death  1 Natural 5 Pending 2 Accident investigation 28a. Date of Injury (Month, Day Year)  28b. Time (Month, Day Year)		284. Describe now	injury occurred	
Division		ertification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury · At home, farm, s building, etc. (Specify)	street, factory, office	28f. Location (Stree City or Town, S	et and Number or Rur State)	al Route Number,
	in on the spirit	O	29a. Certifier  (Check only 2 Medical Exeminer: On the basis of examination and/or				
	To tha Hos within 24 h To tha Fur completely	Medical	(Check only one)  2 Medical Exeminer: On the basis of examination and/or and manner stated.  29b. Signature and title of certifier		004	Data di di di di di di di di di di di di di	Carry Marcal
)	S 7 8 7		MARIA	5 D5072  3. Print)  1 Veterans Hu	5 /	0-10-	2006
	ID		30. Name and address of person who completed cause of death (Item 23a) (Type	SING to ma Hr	II. M. U	post le	MD 211CR
	Sta		31. Date filed (Month, Day, Year)  OCT 18 2006	heale	7		,
	Regist	rar	OCI TO SOOD STATE OF	1			

			1 - For State Registrar	State of M	faryland		artment tificate			nd Me		iene g. N. 0 0	6	34921	
4.4	Physici	an	1. Decedent's Name (First, Middle, Last)  Carroll K. Ross								2. Date of Dear Month October		(år	3. Time of Death 3:15 p	м
	/Medic		4a. Facility Name (If not institution, give s		r)		4b. City, 1	Town, or	Location of		000000	4c. County o		3.13 p	
4.	Examin	er o .	39 Kleis Road		,				Park			Anne		ndel	
	Funeral		5. Social Security Number 6. Sex		ge (In yrs. I	ast birthday)	If Under		If Under 2	4 Hrs. 8	B. Date of Birth (Month, Day,	Vearl	9. Birthp	ace (State or Foreig	gn
	Director		214-24-7964	M 2□F	77	Yrs.	Months	Days	Hours			1928		yland	
	pu ≱		Usual Residence of Decedent  10a. State 10b. County		10c. City	, Town or Lo	cation						1	Od. Inside City Limit	s
	Aaryli f •ho	ō	MD Anne Aru	ndel		everna								1 □ Yes 2 🔀 N	
	the 128e-	rect	10e. Street and Number				10f. Zip	Code			1	0g. Citizen of Wh	nat Coun	try?	
	3a or	Ö	39 Kleis Road					211	46			US	SA		
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatih and Mental Hyglene. Department of Heatih and Mental Hyglene important: if item 27 is marked other then "naturel", or items 23a or 28e-f show suppringing or other traumatic event. The Madical Examiner must be notified at ance.	d by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 X Widowed 4 Divorced	2. Was Deceden Armed Forces 1 X Yes 2 If Yes, Give Year or Dates	? ]No	.	Was Deceded Yes, spec			in? (Spec Puerto Ri	ify Yes or No- ican, etc.)	14. Race Black Specify:	White,	etc.	
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12	within ane. then	Completed	Elementary/Secondary (0-12)	College (1-4or	5+)	iife. L	Buil	,				Bric	c Ma	son	
q 7	filed Hygie other		17. Father's Name (First, Middle, Last)				Dari		18. Mother	's Name (	First, Middle, I	Maiden Sumame		5011	-
Maryland	should be ind Mental is marked o	To Be	Earl Dennis Ross									Hildit			
Mai	d 2 sh th and 7 is n traun		19a. Informant's Name/Relationship (Ty) Noelle O'Toole/Da				g Address Kleis					City or Town, S  MD 21	·	Code)	
e,	1 and Health Iem 27 other tr		20a. Method of Disposition	ugneer	20b. PI	ace of Dispo	sition (Nam	e of		Da	te	20c. Location - C		wn, State	
nor	Pages nent of int: If it	1	1  Burial 2  Cremation 3  R 4  Donation 5  Other (Specify)	emoval from State		veters, cren Vetera			ery Oc	ctobe 2006	er 20,	Crownsv			
Baltimore,	permit. Page Department i important: if eny injury or once.		21. St nature of Juneral Service Livensy			Ba	rranc	0 &	s of Facility	P.A	. Seve	rna Parl	. Fu	neral Hom	e
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	Pnysician /Medical	1	art. Enter he disease, or complishors, or h-art failure. List only or mediate Cause (Final disease or or dition resulting in death)	Due to (or a	non							1 of		Approximate Interval Between Onset and D with	•
	Examiner		equentially list conditions, if any, leading to immediate		v a noscon		Dine	J. G. C.	, .		16-6-4				
	ted nsit	nine	Cause (Disease or injury	Due to (or a	s a consequ	rence or).									
ó	icate be executed physician and s the burial-transit	Examine	that initiated events resulting in death) Last	Due to (or a	s a consequ	ience of):							_		
8760,	ate be nysici he bu	icai	d												
9	ing pt	Med	IF FEMALE:						- ,,						_
P.O. Box	that the death certificate be executed ed by the attending physician and detached for use as the burial-transit	Physician/Medical	23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown	3c. If yes, outcom 1 ☐ Live birth 4 ☐ Pregnant : 9 ☐ Unknown	2 Fetal	death 3	Ectopic pre Other (spe					23d. Date Mont		ry Day Year	
	The law requires that the ate has been signed by th page 2 should be detache	þ	Part II. Other significant conditions con Hypertensic		but not resu	ilting in the ur	nderlying ca	iuse givei	n in Part 1.				ute to th	e cause of death? ably 4 Dinknow	'n
eco	e law rec has bee je 2 shor	Completed									24a. Was a	n 24b. W	ere auto	osy findings availab	le
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Division of Vital Records,	To the Hospitel or Attending Physician: The within 24 burs after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Ir building, e	njury - At ho etc. (Specify		eet, lactory,				II. Location (SI City or Town	reet and Number n, State)	or Rura	Route Number,	
	Hospitel of 124 hours at Euneral Dietely filled is		29a. Certifier 1 ertifying Phys	ician: To the bes	st of my know	wledge, death	occurred a	at the time	e. date and	I place, an	id due to the ca	ause(s) and man	ner as st	ated.	
	To the Hospitel within 24 hours a To the Funeral I completely filled	Medical	(Check only 2   Medical Examilione)	er: On the basis and manner s	of examinat	ion and/or inv	estigation,	in my opi	inion, death	h occurred	at the time, d	ate and place, ar	d due to	the cause(s)	
)	with To	2	29b. Signature and title of certifier	1	1	-MI	29c.	D5	070	25	1	9d. Date signed	Month, I	Day, Year)	
1	0+1		30 Name and address of person who co	mpleted cause of	death (Item	23a) (Type,	Print)	<i>IU</i> )	Mill	lers	ulle	9d. Date signed 10 - 16 - 3	21	108	
	Sta Registr		31. Date filed (Month, Day, Year) OCT 1 82		trar's Signat	K A	book								

State of Maryland / Department of Health and Mental Hygien Certificate of Death Red No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Physician John Bressler Smith 12 M 06: 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Washington Washington County Hospital Hagerstown 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 62 1 XM 2 ☐ F 215-42-3988 Yrs. 10, DELAWARE Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits with the Maryland 10a State 10h County r than "natural", or Iteme 23a or 28e-f ehow the Medical Examinar must be notified at 1 ☐ Yes 2X No MD Washington Hagerstown Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11125 Parkwood Drive 21740 USA Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Baltimore, Maryland 21215-0036 White Specify: δ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) al Hygiene. EMT Instructor County Government 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) and Mental is marked Donald H. Smith, Sr. Louise Dameron 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) or other tree Pamela Smith wife 11125 Parkwood Dr., Hagerstown, MD 21740 20b. Place of Disposition (Name of cometery crematory or other place)
Cumberland Valley Date 20c. Location - City or Town, State 20a Method of Disposition permit. Pages 1 Department of H Importent: If Ite any Injury or ot once. 1 ☐ Burial 2 XCremation 3 XRemoval from State Oct 25 2006 Waynesboro, PA 4 ☐ Donation 5 ☐ Other (Specify) Crematorium 22. Name and Address of Facility M111er-Bowersox Funeral Home 21. Signature of Funeral Service Licensee 521 S, Washington St. Greencastle, PA 17225 ames a. Boulersof 23a. Part N Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** month /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Division of Vital Records, P.O. Box 68760,少 Due to (or as a consequence of): Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant igned by the etten be detached for u 3 Ectopic pregnancy in the past 12 months? Day Month Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2000 Ck 1 🗌 Yes 3 Probably 4 Unknown 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1 Yes 2/ 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Impatient Other: 1 Yes 2 No Medical Certification; To 2 ER/Outpatient 3□ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Alter this 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) Natural 5 Pendina 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Scrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 32. Registrar's Signature 31. Date filed (Month, Year) State 2006 Registrar

State of Maryland / Department of Health and Mental Hygier [ ] ) 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 28 ZOOD UNIENAWA **Physician** /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death Examiner OUTH If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. Apr. 17, 5. Social Security Number 6 Sax 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** 1 ☐ M 2 🔀 F Country Months 83 Director 220-16-6860 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits or 28a-f show other traumatic event, the Medical Examiner must be notified at MD Allegany Cumberland 1 Yes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21502 USA 415 South Street or Iteme 23a Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after or Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or flen any Injury or other traumatic event Black, White, etc. Yes 2 No 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 Yes 2 No Specify Specify: white ò 3X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be May Jeenette (Pyles) Bennett Amos Seymour Bennett 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
517 Haddon Ave. Fxt. Cumberland MD 21502 19a. Informant's Name/Relationship (Type, Print) 517 Haddon Ave. Ext. Richard Shaw son 20b. Place of Disposition (Name of cemetery, crematory or other place)
Zion Memorial Park 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 10/31/2006 Cumberland MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Sign sture of Funeral Service Licen -e <sup>22. Name and</sup> Address of Facility Scarpelli Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 Part. Efter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, hock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician 50 /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence off use as the burial-transit Due to (or as a consequence of): Box 68760. attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Month Year 4 Pregnant at time of death 5 Other (specify) P.O. 9 Unknown Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ 10N₁ Yes 2 🗆 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a Wasan autopsy 20 1 ☐ Yes Hospital or Attending Physician: Be 25. Was case reterred to medical 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA this 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After 1 ANatural after death. investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 24 hours a 1 Physician: To the best of my knowledge death amounted at the time, date and place, and due to the cause(e) and markier as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 25a Conffee Medical (Check only To the within 2 29b. address of person who completed

State

Registrar

31. Date filed (Month, Day, Year)

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	/Medic Examir		4a. Facility Name (If not institution, give street an		4b. City, Town, or Location of Death	Oct 1	5 200 C 0 900 M 4c. County of Death
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	Funeral		Social Security Number 6. Sex	7. Age (In yrs. last birthda	y) If Under 1 Year   If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Yea	9. Birthplace (State or Foreign
L	Director		579-26-7895 ¹□м ²X	81 Yrs.	Workins Days Hours Will.	Nov 9 192	
	and w		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or	Location	111	10d. Inside City Limits
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	r 28a	Director	10e. Street and Number	Lagewa	10f. Zip Code	10a. (	Citizen of What Country?
	h with	교	3939 Germantown Road		21037		USA
	deat	Funeral	11. Marital Status 12. Was	Decedent Ever in U.S. 1. d Forces?	Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puence)	ecify Yes or No-	14. Race - American Indian,
36	or It	y Fu	1 Never Married 2 Married 1 1	res Z∕CXNo s. Give	1 ☐ Yes 2 XNo Specify:	Rican, etc.)	Black, White, etc.  Specify: White
21215-0036	within 72 hours after death with the Maryland jiene. I then "netural", or Iteme 23a or 28a-f ehow Le Medical Examinar must be notified at	d by	3 XWidowed 4 □ Divorced Year	or Dates:			
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212	s within liene. r then "	mo	Elementary/Secondary (0-12) Colle 12	ge (1-40r5+)	min. Manager		ate of Maryland
Q	H CHA	BeC	17. Father's Name (First, Middle, Last)			e (First, Middle, Maid	
/lar	uld be Mental irked c	10 B	Oscar A. Phillips		Florence	J. Kapple	er
Maryland	2 sho and !		19a. Informant's Name/Relationship (Type, Print)		iling Address (Street and Number or Rui	al Route Number, City	y or Town, State, Zip Code)
Σ.	and and and and and and and and and and		Coy E. Simmons, Jr.	The state of the s	4 W. Course Drive,	Annapolis	, MD 21401
ore	t of H H Ite or oth		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal f		position (Name of rematory or other place)	Date 20c.	Location - City or Town, State
Baltimore,	t. Partmen		4 □Donation 5 □Other (Specify)	Lakemon			vidsonville, MD
Bal	permit. Pages 1 and 2 should be Department of Heelth and Mental Importent: If Item 27 is marked eny injury or other treumatic ev		21. Signature of Funeral Service Licensee		22. Name and Address of Facility Hardesty Funeral 12 Ridgely Avenue	Home, P.A.	is. MD 21/01
			23a. Part1. Enterithe disease, or complications to shock, or heart failure. List only one cause		inter the mode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Interiosel	erotic Hear	+ 1715	Onset and Death
	/Medical Examiner		resulting in death)	e to (or as a consequence of):	,	1 15	,-,,,,
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	ted nsit	nlne	if any, leading to immediate Our cause. Enter Underlying Cause (Disease or injury	ordis a consequence or):			
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Вох	death certifi e ettending ed for use as	an/N	250. Tras decedent pregnant	, outcome of pregnancy ive birth 2 Fetal death 3	□Ectopic pregnancy		23d. Date of delivery
Ö.	0 0 0	by Physician/Me	1 Vas 2 No		Other (specify)		Month Day Year
P.O.	that the de ted by the e detached f	F.	Part II. Other significant conditions contributing		and the same of the same	20. 2:4.1	
Records,	8 5 6			to could but not rocalling in the	underlying cause given in Fait i.	1XYes	o use contribute to the cause of death?  2 ☐ No 3 ☐ Probably 4 ☐ Unknown
Ö	w requir been sl	lete					
Re	0 50	Completed				24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
ta	ilcian: Th certificate rector, pag	0	25. Was case referred to medical		26 Olono of Donal	1 Yes 2 N	lo 1 Yes 2 No
<u> </u>	× 0 15	To B	examiner?	□ Inpatient 2 □ ER/Outpati	1000	me 5 esidence	6 Other (Specify)
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Sio	Attending r death.  ctor: After by the fune	atle	2 Accident investigation	, , , , , , , , , , , , , , , , , , , ,	M 1 ☐ Yes 2 ☐ No		
Division of Vital	l or Attende efter death Director: i in by the	Certification:	3 ☐ Suicide 6 ☐ Could not be determined b	lace of Injury - At home, farm, suilding, etc. (Specify)	street, factory, office	28f. Location (Street a City or Town, Sta	and Number or Rural Route Number, te)
	Hospitel of the Punction of Function of Filled in the Punction of Table of		29a Certifier 1X Certifying Physicians To	Cubic Scotts of the section and			
	To the Hoepitel or within 24 hours effet to the Funerel Discompletely filled in	Medical	2 Medical Examiner: On the	the best of my knowledge, do ne basis of examination and/or nanner stated.	ith occurred at the time, date and place, investigation, in my opinion, death occurr	and doe to the cause, ed at the time, date ar	s) and mammer as stated. nd place, and due to the cause(s)
	To the within 2 To the complet	×	29b. Signature and title of certifier	Depute	29c. License number		ate signed (Month, Day, Year)
)	(15)		Millian De	for, mo	D0609	7	10/11/6
		1	30. Name and address of person who completed		10605 6131 Shady		2 1
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			For State	State of Mar				Mental Hyg	iene n	34925
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	Examin	er	4a. Facility Name (If not institution, give				or Location of Death	1	4c. County of D	
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E	Funeral		5. Social Security Number 6. S 023-16-0640	Fex 7. Age 7. A	(In yrs. last birthday)	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day,	Year)	Birthplace (State or Foreign Country)
	Director			X.	83 Yrs.		0	ctober	17,1922	MA
	and *		Usual Residence of Decedent  10a, State 10b, County		IOc. City, Town or Lo	cation				10d. Inside City Limits
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	within 72 hours after deeth with the Maryland ans. then "naturel", or Items 23s or 28s-f show the Mudical Example must be notified at	Completed by Funeral Director	10200 La Plat	a Road		10f. Zip Code		1	0g. Citizen of What	Country?
	seth	erai	11. Marital Status	12. Was Decedent Ev	os in II S	2064			USA	
	ter d	Ë	1 Never Married 2 Married	Armed Forces?	er in 0.3.	If Yes, specify Cub	Hispanic Origin? (Sp pan, Mexican, Puert	o Rican, etc.)	14. Hace - Al Black, W	merican Indian, hite, etc.
99	Ir. or	by	3 ₩idowed 4 Divorced	1 ☐ Yes 2 ☐ No If Yes, Give A Year or Dates:		1□Yes 2ŪXNo	Specify:		Specify:	White
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Maryland 21215-0036	2 should have and have man	_	19a. Informant's Name/Relationship (	Type, Print)	19b. Mailir	ng Address (Street		-	City or Town, State	. Zip Code)
	and 2 eaith a n 27 is		Nancy Morawski,	Daughter						
ē,	s 1 and 7 Health item 27 other tr		20a. Method of Disposition	<u> </u>	20b. Place of Dispo	sition (Name of	o rrace	Date Pla	ta, MD 2( 20c. Location - City	or Town, State
٤	Pages nent of I ant: if ite ury or o		1 Burial 2 Dermation 3 4 Donation 5 Other (Special	Removal from State						Hall,MD
altimore,	글린란군 .		21. Signature of Funeral Service Lice	nsee / MC	0945	A Namerand Addre	assat Excelliby	7,00 0	nariotte	nall, MD
ä	Depa Impo eny ir		Mars 1C.	chula /		AKEHAKT	-ECHOLS	FUNERA:	L HOME,	P.A.
~		1 -	23a. Part1. Enter the disease, or com	plications that caused th		er the mode of dvi	ng such as cardiac	AVE. L	A PLATA,	MD 20646
			shock, or heart failure. List only Immediate Cause (Final	one cause on each line.	44		•	1 5		Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. HZ/		2115	Dem	ent	Q_	
	Examiner			Due to (or as a	consequence of);					
		ē	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a	consequence of):					
	uted 1	드	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury							
	be executed iicien and burial-transit	Examiner	that initiated events resulting in death) Last	C. Due to (or as a	consequence of):					-
760	ate be executed hysicien and he burial-transit	cail		d						
89	ficati g phy as the		(32)	u						
	it the death certifica by the attending ph tached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of	pregnancy				23d. Date of c	lalivan
. Box	Jeath atte	cia	in the past 12 months?	1 ☐ Live birth 2 4 ☐ Pregnant at tir		Ectopic pregnanc Other (specify)	у		Month	Day Year
<u>Р</u> .	the c y the ichec	ysi	9 Unknown	9□ Unknown		2 0 11.0. (4,00.11)				
	The law requires that the te has been signed by though 2 should be detached.	by PI	Part II. Other significant conditions	ontnbuting to death but	not resulting in the u	nderlying cause gr	ven in Part I.	23e. Did tob	acco use contribute	to the cause of death?
Vital Records,	puires n sign							1 ☐ Ye	s 2 No 3	Probably 4 Dunknown
ខ្ល	w rec	Completed								
e e	The lay							24a. Was ar autopsy perform	v prior t	autopsy findings available completion of cause of
ਲ			*					1 ☐ Yes 2	XNo 1 □ Yo	es 2□ No
5	nysician: nis certifica director, p	Be	25. Was case referred to medical examiner?	Hospital:		· all pos Ott		th (Check only one		
Division of	Phys this ral di	.T	1 ☐ Yes 2 X No 27. Manner of Death	1 Inpatient	2 ER/Outpatien	I SLI DOA	4 X Nursing H		nce 6 □Other (Sp	pecify)
5	ding I	Fig	1 Natural 5 ☐ Pending	(Month, Day Y	(ear) Injury	Wo	rk?  Yes 2 □ No	28d. Describe ho	w injury occurred	
2	i or Attandi efter death Director: A i in by the fi	Certification;	2 Accident investigation 3 Suicide 6 Could not be	_	At home, farm, str		1165 2 NO	204 1 104		
2	or A efter Dire	erti	4  Homicide determined	building, etc.	(Specify)	eet, ractory, office		City or Town,	State)	Rural Route Number,
	Hospitel or Attanding Physician: 44 hours alter death. Funeral Director: After this certificately filled in by the funeral director.		29a. Certifier 1 Certifying Ph	voicing. To the best of			1			
	e Hospitei 24 hours e Funeral I letely filled	edical	(Check only 2 Medical Examone)	ysician: To the best of one of the basis of example of the basis of example of the basis of example of the basis of the ba	kammanon and/or m	estigation, in my o	me, date and place, opinion, death occur	and due to the ca red at the time, da	use(s) and manner ite and place, and d	as stated. ue to the cause(s)
	To the Hospitel or within 24 hours effe to the Funeral Discompletely filled in	Me	29b. Signature and title of certifier	and mainler state		29c. Licens			d. Date signed (Mo.	
)	⊢s⊢ŏ		V / ///		$\wedge$					
7			30. Name and address of person who	completed a	U		5545	)	uctober	18, 2006
m	P7		Fatima Hussei	Online ted cause of dea	in (item 23a) (Type,	torm D4	C	101 0	<b>~</b>	
111	Sta	te	31. Date filed (Month, Day, Year)				. Sulte	IUI, Ca	mp Sprir	ngs,MD
100	Registr			2006	w B. A	berte				

DHMH 17 Rev 1/2001

			For State Registrar	State of Ma	ryland		artmen <i>rtificat</i>			and Mer	-	/	006	34926
			Registrar  1. Decedent's Name (First, Middle, Last	)		- 00	lincan	e oi L	Jeani	2.	Date of Dear	eg. No.	• • •	3. Time of Death
П	Physici		Mary K		Sir	nns	Oh				Month	Day	Year	1:15 AM
	/Medic Examin		4a. Facility Name (If not institution, give	street and number)	~ VI	Too	4b. Gity	Town, or	Location o	of Death .		4c. G	ounty of Death	11
100		Ŭ.	Glen Burnie	Itealt	ħ		G	en	Bu	SIMI	9	AV	me 1	trundel
	Funeral		5. Social Security Number 6. Se	7. Age		ast birthday)	If Under Months	1 Year Days	If Under 2	24 Hrs. 8. Min.	Date of Birth (Month, Day	Year)	9. Birth	place (State or Foreign intry).
	Director		Usual Residence of Decedent	, W 22,	78	Yrs.				Ма	λ /'Ta	928	West	Virginia
	land ow		10a. State 10b. County		10c. City	, Town or Lo	ocation							10d. Inside City Limits
	Mary Fish	to	MD Garrett		Swai	nton								1 ☐ Yes 2X No
	h the	Funeral Director	10e. Street and Number				10f. Zip	Code	_		1	0g. Citize	n of What Cou	intry?
	th wit	a D	280 Meadow Mountai	n Trail			215	61				USA		
	r dea	Juei	11. Marital Status	12. Was Decedent E Armed Forces?		3. 13.	Was Deced	ent of Hi	spanic Orig	gin? (Specify , Puerto Ric	y Yes or No- an, etc.)	14	. Race - Ameri Black, White	
36	s afte	by Fi	1 ☐ Never Married 2 ☐ Married  3 🗶 Widowed 4 ☐ Divorced	1 ☐ Yes 2 📉 N If Yes, Give Year or Dates:	0		1 🗆 Yes	2 <b>X</b> ] No	Specify:			s	pecify: Whi	ite
21215-0036	72 hours after death with the Maryland natural', or tlems 23e or 28e-f show iscal Examiner must be notified at	ed t	15. Decedent's Edu			16a. Dece	dent's Usua	al Occupa	ition			16b. Kind	of Business/Ir	
215	within 72 iene. then "na the Medi	Completed	(Specify only highest grade Elementary/Secondary (0-12)	e completed) College (1-4or 5-	+)	(Give life.	kind of wor DO NOT us	rk done d se retired,	luring most )	t of working				,
21;	d with	O O	12	College (1 10)	.,	Home	Nurse	•				Nurs	ing	
pu	be filed tal Hygid d other event,	Be	17. Father's Name (First, Middle, Last)								irst, Middle, I	Maiden S	umame)	
yla	should but marked	To	Andrew Jackson Col							s Shaf				
Maryland	s 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene. Item 27 is marked other then "natural", or Items 23e or 28e-f show other treumatic event, I've Medical Examinar must be notified at		19a. Informant's Name/Relationship (T)  Carol A. Hendersor										Fown, State, Zi	
	1 and Heali Iem 2 other		20a. Method of Disposition	, baagiice	20b. Pl	ace of Dispo	sition (Nan	ne of		n Trai	l, Swa		ation - City or T	21561 own, State
non	9 = 10		1 ☐ Burial 2 X Cremation 3 ☐ F	temoval from State	1	metery, crei ntrv S				Oct.	21, 20	006 D	avidsvi	ille, PA
Baltimore,	그 본 본 문		21. Signature of Furteral Service Licens	90									Homes,	
ä	Depa Depa Impo eny ir	1 9	La Zen El	man							ville,		21536	
			23a. Part1. Enter the disease, or comp shock, of heart failure. List only o	ications that caused ne cause on each lin	the death	. Do not ent	ter the mod	e of dying	g, such as	cardiac or re	spiratory arr	est,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Cong	TLRY	kue,	Hear	E/7	Fare	mas	DI	Co	make	Onset and Seath
	/Medical Examiner		resulting in death)	Due to (or as a	consequ	ence of):	/	222		A . 'F	- 7			
	=xa	7	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a	consequ	ence of):	aus	100	M	y +	acci	ne		
	uted I Insit	Examlner	Cause (Disease or injury	Par	no	1/2/1	Arx	the	, 4	risec	Re			
Ć,	exection and sale and sale and sale.	Exa	that initiated events resulting in death) Last	Due to (or as a	consequ	ence of):	-	, /		/				
8760,	death certificate be executed e attending physician and od for use as the burial-transit	Ical	(	1. HYGE	0)7	Mu	ud							
9	ing ph a as th	Med	IF FEMALE:			/								
Вох	eath certific attending p	ian/l	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of 1☐Live birth	2 🗆 Fetal	death 3[	Ectopic pr					23	d. Date of deliv Month	ery Day Year
0.		Physician/Medical	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4□Pregnant at t 9□Unknown	time of de	ath 5	Other (sp	ecify)						,
<u>α</u>	es that the de igned by the be detached		Part II. Other significant conditions co	tributing to death bu	it not resu	Iting in the u	nderlying c	ause give	n in Part I.		23e. Did tol	pacco use	contribute to t	he cause of death?
ds,	law requires as been sign 2 should be	d by	Hypert	MSIUL	Re	any	B	fle	RE	e	1 □ Ye	s 2 🗹	No 3 Pro	bably 4 Unknown
Ö	w requires been si	lete	Bloke	mu	5	ad	Sta	66			24a. Wasa	n	24b. Were auto	opsy findings available
Vital Records,	0 0	Completed	- July 1			10	-				autops perforr	y	prior to co death?	mpletion of cause of
ital	iclen: Th certificate rector, pag	Be C	25. Was case referred to medical						26. Place	of Death (C	heck only on		10,103	2010
of V	dis is	ToE	examiner? 1 □ Yes 2 No			ER/Outpatier	nt 3 🗆 DQ	Othe	1. 4 Z HO	rsing Home	5 🗆 Reside	ence 6[	□Other (Specia	fy)
n o	ding P	on:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day	Year)	28b. Time o Injury		8c. Injury Work			. Describe ho	ow injury o	occurred	
isio	Attending r death. ector: After y the fune	icat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Inju	ny - At hou	ma farm at	M fastas		/es 2□N	-	Location (St	root and	Number or Pur	al Route Number,
Division	I or Attendater deatl Director: I in by the	Certification:	4 Homicide determined	building, etc.	. (Specify,	)	eet, ractory	, once		201.	City or Town	n, State)	variber or har	ar noble wamber,
	spite nours nerel		29a. Certifier 1 Certifying Phy	sician: To the best o	f my know	vledge, deat	h occurred	at the tim	e, date and	d place, and	due to the ca	ause(s) ai	nd manner as s	stated.
	To the Hospitel or Attending Ph within 24 hours after death.  To the Funerel Director: After th completely filled in by the funeral	edical	(Check only 2 Medical Exami	ner: On the basis of and manner stat	examinati	ion/and/or in	vestigation,	, in my op	inion, deat	th occurred a	at the time, d	ate and p	lace, and due t	o the cause(s)
	To the To the Comp	×	29b. Signature and title of certifier	hr fo	row	1	290	License	,		i i	-	signed (Month,	
)			CARLOS N. PA	TALING	SHU		MO	D	184	26	6	CTO	36P 1	9,2006
	2		arme and address of person who co	empleted cause of de	ath (Item	23a) (Туре,	Print)	01	nai	_				
2	2		31. Date filed (Month_Day_Year)	32. Registra	-			2/6	703					
	Sta Registr	_	OCT 2 4	2006	in a signal	A	Anna M	2.0						
		1		10 may 1843	J. 100	- W	100000000000000000000000000000000000000	100						

		For State Registrar	State of	Marylan		artment			ind M		giene Rog. N2	006	34927		
Physicis	200	1. Decedent's Name (First, Middle, Last	)					•		2. Date of De. Month		Year	3. Time of Death		
Physicia /Medic	_	Ethel Virginia So					Octobe	r 22,	2006	6:45 A M					
Examin	er	4a. Facility Name (If not institution, give Oakland Nursing ar		*	er	46. City, Oakl		Location o	f Death			4c. County of Death  Garrett			
Funeral		Social Security Number 6. Se	x 7.	Age (In yrs. i		If Under	1 Year	If Under 2		8. Date of Birt		9. Birt	hplace (State or Foreign		
Director		217-10-7105	]M 2[ <b>X</b> F	88	Yrs.	Months	Days	Hours	Min.	8. Date of Bird (Month, Da July 7	, 1918		t Virginia		
and		Usual Residence of Decedent  10a. State 10b. County		10c. City	y, Town or Lo	cation							10d. Inside City Limits		
Mary -f •hc	tor	MD Garrett		Mt.	Lake	Park							1X Yes 2 □ No		
th the	irec	10e. Street and Number			2010	10f. Zip	Code				10g. Citizen	of What Co	ountry?		
death with the Maryland me 23a or 28a-f ehow Errust be notified at	Funeral Director	708 I St.				215					USA				
items items	nue	11. Marital Status  1 □ Never Married 2 □ Married  3 ※ Widowed 4 □ Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Yes 2 ※ No If Yes, Give Year or Dates:				Vas Deced f Yes, sp <i>ec</i>	ent of His ify Cubar	spanic Orig n, Mexican	gin? (Spe , Puerto	ecify Yes or No Rican, etc.)	- 14.	14. Race - American Indian, Black, White, etc.			
5-UUSO 72 hours after naturel', or ite	þ					1 ☐ Yes 2 No Specify:						ecify:	hita		
72 ho	Completed	15. Decedent's Edu (Specify only highest grad			16a. Deced	lent's Usua kind of wor	l Occupa	ition	of worki	na	16b. Kind	Mhite  D. Kind of Business/Industry			
d within giene. rr than "	mpi	Elementary/Secondary (0-12)	College (1-4	or 5+)		kind of wor DO NOT us	e retired)	)	O. 1101111	9					
o filed within all Hygiene. other than 'vent, the Mu	e Co	2 Homemaker  17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Last)							(First Middle	Own Home					
id be fill entail Hy ked oth	To Be	Charles L. Layman									Waldely Gay	,,,,,,,,			
ary shou and M mar		Charles L. Layman  Elizabeth Pote  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)											Zip Code)		
e, Mal 1 and 2 st Health and em 27 le n ther traun		Linda S. Sanders/I	aughter					d Rd.	, Oa	kland,	MD 2	1550			
DESITIMOTE, MATYIANG ZIZIS-UUSO permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Deperment of Health and Mental Hygiene. Deperment of Health and Mental Hygiene. The mary injury or other traumatic event, the Mudical Example must be notified at once.		20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ I	Removal from Sta	ate C	lace of Dispo emetery, cren	natory or ot	her place			ate		-	Town, State		
Saltimor Sermit. Pages Depertment of Importent: If it iny injury or o		4 Donation 5 Other (Specify)  Bear Creek Cemetery Oct. 25, 2006 Accident, MD  21. Signature of Fun, al Servic Licensee  22. Name and Address of Facility Newman Funeral Homes, P.A.													
Depermination of the second of		21. Signature of Purifical Service Closens	ee man	. 1						man Fur sville		Homes 21536	, P.A.		
E Militar		23a, Part1. Enterthy disease, or comp	lications that cau	sed the death								21330	Approximate		
Physician		shock, or he it failure. List only one cause on each line.  Immediate Cause (Final disease or condition)  a. a the wsc length of cavdio vuscular disease.  (o y ears													
/Medical Examiner		resulting in death)  Due to (or as a consequence of):									( ) eurs				
Examine	_	Sequentially list conditions													
uted d ansit	Examin	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	uence of):												
be executed ricien and burial-transit	Еха	resulting in death) Last	Due to (or	as a consequ	uence of):										
ate ate	edicai		d												
= Drei	/Med	IF FEMALE:	23c. If yes, outco	me of precina	ncv										
of the part of the control of the co	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No	death 3	☐Ectopic pregnancy ☐ Other (specify)					23d. Date of delivery  Month Day Year						
by the archec	hysi	9 Unknown	Tes 2 to to												
ecords, F.O. I	by P	Part II. Other significant conditions co	ntributing to deal	th but not resu	ulting in the ur	underlying cause given in Part I. 23e. Did					tobacco use contribute to the cause of death?				
faw requires as been sign	ted	diobetes me	litus	+1/	be to	CU				1 🗆 1	∕es 2 🚾	2 Sto 3 Probably 4 □Unknown			
has b	Completed	cerebrous	culor	d; 5-	ease	2				24a. Was autor	osy	y prior to completion of cause of			
VICAL MEC sicien: The law s certificete has b lirector, page 2 s		demontia, senile onset 1 yes 216 No								2 No	death?				
Of VICA Physicien: rthis certific ral director,	o Be	25. Was case referred to medical examiner? 1 □ Yes 2 □ No	Hospital:	atient 2	ER/Outpation	2 7 00	Otho	-		n <i>Check onl</i> o		045 (0	7.		
On Of Vital Meding Physicien: The In. After this certificate ha funeral director, page	$\vdash$	27. Manner of Death	28a. Date of		28b. Time of Injury		Bc. Injury Work			28d. Describe i			ory)		
VISION Attending or death. Fector: Afte	atio	1 Natural 5 Pending Investigation	(WOTH),	Day 16a/)	injury	М		es 2□N	10						
or Att fler d Direct in by t	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of building	Injury - At ho , etc. <i>(Specif</i> y	ome, farm, stre	eet, factory	factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State)								
plitel ours e erel C		29a. Certifier 1 Certifying Phy	eician: To the hi	net of my kno	wledge death	annumed a	at the time		1 -1						
To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	edical	(Check only 2 Medical Exam	ner: On the basi and manner	is of examinat	tion and/or inv	restigation,	in my op	inion, deat	h occurr	ed at the time,	date and pla	manner as ce, and due	to the cause(s)		
To the within To the comp	Me	29b. Signature and title of certifier			wit		License				∠9d. Date si	gned (Monti	h, Day, Year)		
		Alan	Men	non	_		Vυ	02	5-1	59 1	Datob	er 2:	2,2006		
1		30. Name and address of person who c	h		23a) (Type,	Print)	D	. 2	47	1	12.4	- Mar	2,2006		
Sta	te	31. Date filed (Month, Day, Year)	Valum 32. Reg	ann istrar's Signa	ture	70	00	/	7/	Macio	TELY	1.1	, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		
Registr	104.0	OCT 2 4	2006	Gallerin o	A A	Samuel.	g								

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Yeer Physician 7:05 a.m. Somerville October 22, 2006 Vincent /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 24430 Pincushion Road Leonardtown
If Under 1 Year If Under 24 Hrs. St. Mary's 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 10XM 2□ F Yrs. Director 214-32-8330 July 31, 1933 Maryland Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. fnside City Limits item 27 is marked other than "neturel", or items 23a or 28e-f show other traumetic event, the Mcdical Examinar must be notified at 1 Yes 2 No Directo St. Mary's Maryland Leonardtown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 24430 Pincushion Road 20650 Funeral United States 12. Was Decedent Ever in U.S. Armed Forces?

1 📉 Yes 2 🗍 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-tf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 ☐ Never Married 2 Married Saltimore, Maryland 21215-0036 1 Yes 2 No **Black** Specify: δ Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Supervisor Federal Government permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked othe any injury or other traumetic event gote. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Xavier Frederick Rosie Queenie Mae Somerville 19a. Informant's Name/Refationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Imogene Somerville/Wife 24430 Pincushion Road, Leonardtown, Maryland 20650 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Bunal 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Queen of Peace Cem. 10-26-2006 Helen, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Brinsfield Funeral Home, P.A. M01206 Kyle S. Simons 22955 Hollywood Road, Leonardtown, MD 20650-0279 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intervat Between fmmediate Cause (Final disease or condition resulting in death) CARINAC ATTANIAS **Physician** /Mèdical Examiner CONGESTIVE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the attending physician and hed for use as the burial-transit COTONAR ATL TONY Due to (or as a consequence of): P.O. Box 68760. Physician/Medical IF FEMALE 23c. ff yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) ☐Yes 2☐No detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part f. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ pege 2 should be 1 Yes 2 No 3 Probably 4 DUnknown Completed KNEE MLATERM 24b. Were autopsy findings available prior to completion of cause of death? autopsy 1 Yes 2 No 1 ☐ Yes 2 No ospital or Attending Physician: hours after death. Ineral Director: After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Presidence 6 Other (Specify) Certification: To 1 🗌 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Maturat 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \( \text{Homicide} \) within 24 hours a the Hospitai 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifiei Medical 29c. License number 29b. Signature and title of certifier. 29d. Date signed (Month, Day, Year) MD 10-24-06 10+ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Horiywood 14AJBINDER SMAM ASSOCIATES 67.11 31. Date filed (Month, Day, Year) 32. Registrar's Signature Státe Registrar 2006

DHMH 17 Rev 1/2001

			For State Registrar	State of M	Maryland		artment tificate			and M		giene Reg. No.	006	349	29
	D1		Month Day Year										3. Time of		
	Physicia /Medic		STEPHEN ROBERT SANDLER								OCTOBER	16	2006	8:50	Рм
	Examin	er	4a. Facility Name (If not institution, g		4b. City, T	own, or	Location o	of Death			4c. County of Death				
1			5. Social Security Number 6. Sex 7. Age (In yrs. last birthday					NSV.	ILLE If Under:	24 Hrs.	8. Date of Birt		QUEEN ANNE'S  9. Birthplace (State or Foreign		
	Funeral Director		184-32-7450	1 <b>X</b> M 2□F	65	Yrs.		Days	Hours	Min.	(Month, Da 04/22/	y, Year)	NY Co	runtry)	, i oroigii
		-	Usual Residence of Decedent		- 0.5				04/ 22/ 1341 N1						
	how		10a. State 10b. County		10c. City	, Town or Lo	cation							10d. Inside Cit	
death with the Maryland	e Ma	cto	MD QUEEN A	NNE'S	STEV	ENSVI								1 🗆 Yes	2 <b>X</b> 1110
	or 2	Director	10e. Street and Number				10f. Zip (					171	of What Co	ountry?	
	• 23e	rai	500 TALBOT RD.	12. Was Decede	nt Ever in 11 S	2 12 1	2166		enanie Ori	nin? (Sn	ecify Yes or No	USA 14	Race - Ame	nican Indian	
_	item item	Funeral	11. Marital Status  1 Never Married 2 Married	Armed Force	s?	J. 13.	f Yes, specif	fy Cubar	n, Mexican	n, Puerto	Rican, etc.)		Black, White		
20	urs at	by	3 Widowed 4 Divorced		1 Yes 2	No.	Specify:			Sp	Specify: WHITE				
215-0036	within 72 hours after death with the Marylar ene. Than "naturel", or iteme 23a or 28a-f show the Madical Examiner must be multied at	Completed	15. Decedent's (Specify only highest	Education		16a. Dece	dent's Usual	Occupa	ition lurina mos	t of work	ina	16b. Kind	of Business/	siness/Industry	
7	ithin 19.	nple	Elementary/Secondary (0-12)	College (1-4d	or 5+)	life.	DO NOT use	e retired)	)						
2	filed w Hygier Sther th	ပ္ပ	17. Father's Name (First, Middle, La	5+		POLIT	LCAL M				ANT (First, Middle,			ADVERTIS	SING
Maryland	ntal H	Be		31/									,,,,,,,		
2	should nd Me mark matic	ဥ	ABRAHAM SANDLER  19a. Informant's Name/Relationship	(Type, Print)		19b. Mailir	ng Address (	(Street a			MELNIC  al Route Number		own, State, 2	Zip Code)	
	and 2 : Baith ar n 27 is		SHARON ANNSANDL	ER / WIFE		500	<b>FALBOT</b>	RD.	. ST	EVEN	SVILLE,	MD 2	1666		
<b>•</b> •	-ISS		20a. Method of Disposition			ace of Dispo	sition (Name	e of		C	Date		ion - City or	Town, State	
	Pages nent of ant: If it		1 XBurial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe		STEV	ENSVI	LLE CE	METI	ERY 1	0/20	/2006	STEVE	NSVILI	E, MD	
Balt	permit. Pag Department Importent: It any injury o		21. Signature of uneral Service Li	censee	``	F)	ELLOWS 06 SHA	Addres HI MRO	ELFEN CK RD	BEIN	& NEWN	IAM FU MD 2	NERAL 1619	HOME, I	P.A.
/Mo Exa	death certificate be executed  Medical Example 1  M	lical Examiner	shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that intitated events resulting in death) Last	a. Due to (or b. Due to (or c.	as a consequ as a consequ as a consequ	ience of):	Pauc	Ned	as (	Cau	cer			Onset and the control of the control	Stas
O. Box 68	at the death certifica by the attending ph tached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  1 ☐ Unknown  23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐								23d. Date of delivery Month Day Yea				Year
ت.	that If	Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in P							t I. 23e. Did tobacc			co use contribute to the cause of death?		
ds	quires that n signed b	d by							_		10	Yes 2	No 3□Pr	robably 4 🗍	Jnknown
II Records	Physician: The law requires that r this certificate has been signed b ral director, paga 2 should be dela	Completed									24a. Was auto perfo	an cosy ormed? 2 2 No	24b. Were au prior to death? 1 🗆 Yes	utopsy findings completion of c	available ause of
Vital	Physician: r this certifica ral director, I	Be	25. Was case referred to medical examiner?	Hospital:				Othe	20		h (Check only				
	Phys r this ral du	٠ <u>.</u>	1 ☐ Yes 2 No 27. Manner of Death	1 🗆 Inp		ER/Outpatier 28b. Time o			4 🗆 140	ursing Ho	me 5 Resi 28d. Describe		Other (Spe	city)	
5	6 eg	tion	1 Natural 5 Pending 2 Accident investiga	28a. Date of (Month,	Day Year)	Injury	м	Bc. Injury Work 1 🗆 \	<br Yes 2 ☐	No		. ,			
Division of	i or Attending Paffer death. Director: After t	Certification:	2 Accident 3 Suicide 4 Homicide  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  28f. Location (Street and Number or Rural Route Injury - At home, farm, street, factory, office building, etc. (Specify)								ural Route Num	nber,			
_	Hospita 4 hours Funerei	Medical C		Physician: To the becaminer: On the basi	s of examinat										i)
	To the within 2 To the complete	Me	29b. Signature and title of certifier		hall	1	29c.	License	number	6	4	29d. Date :	signed (Mont	h, Day, Year)	,
			30. Name and address of person w	ho completed cause	or death (year)	PSa) (Type:	Zrint)	BX	SW	Ani	MADIMI	(111)	171	401	
Υ.	Sta		31. Date filed (Month, Day, Year)		jistrar's Signal	ture	1116	~	300	1010	IVNTUU	N	1) 0	101	
	Regist	rair	OCT 2	0 200F	Seeye	D.	4084	U							

			For State	State	of Marylar		artmen rtificate					,	2005	34930	
			Registrar  1. Decedent's Name (First, Middle	2. Date of 1											
	Physicia		Elizabeth Franc	Month					22 2006 15 47 M						
	/Medic Examin		4a. Facility Name (If not institution,		4b. City,	Town, or	Location of	of Death	cc / /	1 7	County of Deal	h			
	LAGIRIII	C1	Washington Cou	nty Hosp	ital		На	igers	town			1	Washing	ton	
	Funeral			6. Sex	7. Age (In yrs.	last birthday)	If Under	1 Year	If Under		8. Date of Birt	h	9. Birt	hplace (State or Foreign	
	Director		213-24-8000	1□M 2ਊ F	77	Yrs.	Months	Days	Hours	Min.	Oct. 1			ryland	
	p ,		Usual Residence of Decedent		10- 0										
не Мапуlar	anyla ehov	-	10a. State 10b. County		100. 0	ity, Town or Lo	cation							10d. Inside City Limits 1   Yes 2   No	
	Ba-f	Director	Maryland Wash		На	gerst					40 011				
	with t	급	10e. Street and Number				10f. Zip		^			iug. Citiz	zen of What Co	untry?	
	eath	era		11 W. Baltimore St., Apt. 40				2174		inin? (Sno	ofy Vac or No.		USA 14. Race - Ame	rican Indian	
	ter d	Funeral	1 ☐ Never Married 2 ☐ Marri	Armed F		7.3.	if Yes, spec	offy Cubar	n, Mexicar	n, Puerto F	cify Yes or No- Rican, etc.)	Black, White, etc.			
Š	urs at	þ	3 ☐ Widowed 4 ☑ Divorced	If Yes, C Year or	Sive .		1 ☐ Yes	2☑ No	Specify:			Specify: white			
5	2 hou	ted	15. Decedent	s Education			dent's Usua					16b. Kir	Kind of Business/Industry		
-	P. Bo Tr	ple	(Specify only highes Elementary/Secondary (0-12)	(1-4or 5+)	life.	kind of wor DO NOT us	nk aone a se retired)	uring mos )	t of workir	)g					
7	or th	Completed	11	D	,	sa	les c	lerk				depa	artment	store	
2	al Hy al Hy d oth	Be (	17. Father's Name (First, Middle, I						18. Mothe		(First, Middle,		Sumame)		
Z Z	Ment Ment arked	၉	Wilbur R. Lorshbaugh Irene Carper												
9	2 short		19a. Informant's Name/Relationsh			1	-						Town, State, 2		
2	end lealth m 27 her tr		Delores M. Smit	h - frie					uth 1					and 21742	
5	permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Importent: If term 27 is marked other than "naturel", or Iteme 23s or 28s-f show importent: If term 27 is marked other than "naturel", or Iteme 23s or 28s-f show eny injury or other treumatic event, the Madical Examinar must be notified at once.		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation	3 □Removal from	n State	Place of Dispo cemetery, crea	matory or o	ther place	1		ate	20c. Lo	cation - City or	Town, State	
	tmen tent:		4 □ Donation 5 □ Other (Sp		Ha	gersto								Maryland	
9	Depermine Depermine Important in procession		21. Signature of Funeral Service L	Licensee	2,		/						RAL HOM		
	48204		23a. Part1. Enter the disease, or	someliastions that	consideration does								m, Md.	Approximate	
			shock, or heart failure. List	only one cause on	each line.				1,00	-			1	Interval Between Onset and Death	
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. IN	1 PHYS	EMM	. (	4160	INIC	. 151	KONCI	111	/ 3	YEARS	
	Examiner		Due to (or as a consequence of):									1,5000			
		40	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	quence ol):	te ol):							96110			
	nsit	듣	Cause (Disease or injury	INF F	= RESPIRATORY FAILURE								1401175		
,	execu n and ial-tra	Examiner	that initiated events resulting in death) Last	C. Due to	(or as a consec	quence of):	-171 - 1	7	, , ,					110010	
2	cate be executed hysicien and the burial-transit	dicai	<b>)</b>	L d											
5	ifficat g ph) as th	ed													
5	h cer endin	<u></u>	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death 3					B DEctopic pregnancy					3d. Date of del	very	
	deat ne att ed for	300	in the past 12 months? 1 ☐ Yes 2 ☐ No		gnant at time of		Other (sp						Month	Day Year	
	et the	Physician/Me	9 🗆 Unknown												
ń	es th igned be de	ρ	Part II. Other significant conditio	ns contributing to	death but not re	sulting in the u	nderlying ca	ause give	n in Part I.			obacco use contribute to the cause of death?			
5	plnoi s ues	ted					-				101	′es 2∟	2 No 3 Probably 4 Unknown		
ב ט	law las be	ple									24a. Was autop		24b. Were au	topsy findings available completion of cause of	
	The ete h page	Completed									perfo	med? 2 No	death?	2□ No	
2	cian: ertific sctor,	Be (	25. Was case referred to medical examiner?						26. Place	of Death	(Check only o	пө)			
5	hysi this c	၉	1 Yes 2 No			EN/Outpatier			4 🗀 190				Other (Spec	cify)	
	After	Ö	27. Manner of Death 1 ☑Natural 5 ☐ Pending	(Mo	e of Injury onth, Day Year)	28b. Time o Injury		8c. Injury Work			8d. Describe h	low injury	occurred		
2	tend death tor: /	cat	2 Accident investig	ot bo	M 1 Tes 2 No					281. Location (Street and Number or Rural Route Number.					
5	or A after Direct in by	Certification;	4 Homicide determi		ding, etc. (Speci		eet, ractory	, OTICE		-	City or Tou		I Number or HL	rai Houte Number,	
-	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 54 hours eliter death.  On the Funerel Director: Alter this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit.		29a. Certifier 1 Certifying	g Physician: To the	ne best of my kn	owledge, deat	h occurred	at the tim	e, date an	nd place a	nd due to the	Cauca(e)	and manner an	stated	
	# Ho: 24 h Fur etely	Medical	(Check only 2 Medical E	examiner: On the	basis of examination	ation and/or in	vestigation,	in my op	inion, dea	th occurre	d at the time,	date and	place, and due	to the cause(s)	
	To th Fo th	Me	29b. Signature and title of certifier	1	1 1		29c	. License	number			29d. Date	signed (Monti	n, Day, Year)	
			► L. 1/1/1	4/21/	V11(157	FL		00	1177	(143		10	173/1	6	
	,		30. Name and address of person v	no completed ca	use of death (Ite	m 23a) (Type,	Print)			, ,	2.2	- 0	( ) ( )		
<i>H</i>	+1		11110 MEDI	EAI (Ai	11,105	KI)	1+1.	1950	STU	NN	MO	2	1146		
	Sta Registr		31. Date filed (Month, Day, Year)	4 2006 32.	Registrar's Sign	ature	1 .								
			Pag		- C	174 153	A 100 1	-							

DHMH 17 Rev 1/2001

			For State Registrer	State of Ma		irtment of Health at tificate of Death	nd Mental H	ygiene Reg. No 2	2006	34931		
			Decedent's Name (First, Middle, Last)	2. Date of D	eath		3. Time of Death					
	Physicia			Jeanne G	ray Spickl	er	Month Octob	Day er 22	Year 2006	12.42 A M		
j.	/Medic Examin		4a. Fecility Name (If not institution, give		cuy opica.	4b. City, Town, or Location of			ounty of Death	12112 11		
			Avalon Manor Nursing Home Hagerstown Wa							n		
	Funeral Director		5. Social Security Number  6. Sex  7. Age (In yrs. last birthday) If Under 1 Year   If Under 24 Hrs.   8. Date of Birth (Month, Day, Year)   Months   Days   Hours   Min. (Month, Day, Year)   Month,						9. Birthp Court	place (State or Foreign htry) PA		
	and		Usual Residence of Decedent  10a, State 10b, County 10c, City, Town or Location						1	IOd. Inside City Limits		
	f sho	ō	W Jefferso		Chaphand	storm				1 ☐ Yes 2X No		
	28a	Director	10e. Street and Number	<b>LL</b>	Shepherd	10f. Zip Code		10g. Citize	en of What Cou	ntry?		
	h with	O E	6456 Engle Moler	s Road		25443			USA			
	deat	Funeral		12. Was Decedent E Armed Forces?	ver in U.S. 13.	Was Decedent of Hispanic Original Yes, specify Cuban, Mexican,	in? (Specify Yes or Puerto Rican, etc.)	No- 14	4. Race - Americ Black, White,			
Maryland 21215-0036	be filed within 72 hours after death with the Maryland hat Hygiene. od other then "natural", or ltems 23a or 28a-f show event, the Medical Examinar must be notified at	Ď	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 XYes 2 □ No If Yes, Give 1 Year or Dates: 1	943-1945	1 ☐ Yes 2 No Specify:		5	Specify: Whi	.te		
2-0	72 hc	Completed	15. Decedent's Edu (Specify only highest grad		(Give	dent's Usual Occupation kind of work done during most	of working	16b. Kind	d of Business/In	dustry		
121	within iene. then	g	Elementary/Secondary (0-12)	College (1-4or 5-	+)	DO NOT use retired)			1			
22	Hygie v Hygie other t	ပိ	12 17. Father's Name (First, Middle, Last)		Licen	sed Pratical N	UTSE 's Name (First, Midd		spital Sumame)			
aŭ	D 9 7 7	To Be	William Lemon Gr	av		Lau	ra Gertru	de Mil	1er			
ary	d 2 should th and Men 7 is marke traumatic	-	19a. Informant's Name/Relationship (T)		19b. Mailii	ng Address (Street and Number				Code)		
	tra tra		Jeffrey P. Spickl	er - Son	P. O	. Box 700 - Sh	epherdsto	wn, WV	25443			
ore	- F 5 5		20a. Method of Disposition  1 Burial 25 Cremation 3 DF	lamoval from State	20b. Place of Dispo cemetery, crei	sition (Name of matory or other place)	Date	20c. Loc	ation - City or To	own, State		
Ϊ	Pages ment of ant: If it ury or o		4 Donation 5 Other (Specify)		Hagerston	on Crematory 1	10/25/06		erstown	. MO.		
Baltimore,	permit. Pages Department of Plimportant: If ite eny injury or of pages.		21. Signature of Funeral Service Licens	99		2. Name and Address of Facility	Lackies			ton Funeral		
	40 = a		Kobe A J. Sp	ene	M970	or the mode of thing, such as a	Harpers	-	WV 254	25 Approximate		
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition									
	Physician /Medical		disease or condition resulting in death)	a Cal				CX				
	Examiner		Due to (or as a consequence of):									
	₹	Je.	Sequentially list conditions, if any, leading to immediate	Due to (or as a	achaequando of):							
	cuted nd ransit	Examine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	G								
ő	e exe ien af urial-t		resulting in death) Last	Due to (or as a	consequence of):							
8760,	cate be executed obysicien and the burial-transit	dlcal		d								
Box 6	The law requires that the death certificate be executed ate has been signed by the eltending physicien and page 2 should be detached for use as the burial-transit	ω .	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of	2 ☐ Fetal death 3 [	∃Ectopic pregnancy		23	3d. Date of deliv	ery Day Year		
P.O. E	at the dea by the el	Physiclan/M	1 Yes 2 Ho	4☐ Pregnant at 9☐ Unknown	time of death 5[	Other (specify)	T					
	res that igned to be det	Ď	Part II. Other significent conditions co	ntributing to death bu	it not resulting in the u	nderlying cause given in Part I.				he cause of death?		
ord	w require been si	ted					1 Yes 2 No 3 Probably 4					
of Vital Records,	elaw n hasbo	Completed					24a. W	topsy	24b. Were auto prior to co death?	opsy findings available impletion of cause of		
H	ysician: The is certificate hadirector, page	S					1 ☐ Yes	rfòrmed? 2 ₩ No	1 Yes	2 □ No		
Vita	ician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:		Othor	of Death (Check onl					
of	Phys this ral dir	5	1 Yes 25 No	1 Inpatie		IL 3 DOA 4 SYNU	sing Home 5 Re			fy)		
o	ding h. After fune	to	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day	Year) Injury	f 28c. Injury at Work?  M 1 \( \text{Yes} \) 2 \( \text{In} \)		. ,				
Division	Atten deat octor: yy the	flca	3 ☐ Suicide 6 ☐ Could not be		ıry - At home, farm, st	reet, factory, office	actory, office 28f. Location		(Street and Number or Rural Route Number,			
á	s afte	Certification:	4 Homicide	building, etc	:. (Specify)		City of	Town, State)				
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifice completely filled in by the funeral director, I	Medical (	29a. Certifier 1 Certifying Phy (Check only one)	rsicien: To the best of iner: On the basis of and manner sta	examination and/or in	h occurred at the time, date and vestigation, in my opinion, deat	d place, and due to the hoccurred at the time	ne cause(s) a le, date and	and manner as s place, and due t	stated. to the cause(s)		
	ro the vithin o the	Me	29b. Signature and title of certifier			29c. License number		29d. Date	signed (Month,	Day, Year)		
	->-0		120			06222	3	161-	24-6			
			30. Name and address of person who c	ompleted cause of de	eath (Item 23a) (Type	Print)						
É	14-16+1		Farid Murshed, M	D - 1126 (	Opal Court	- Hagerstown,	MD 21740					
		ate	31. Date filed (Month, Day, Year)	32. Registra	ar's Signature	1.1.						
51	Regist		00124	LUUD There	ar's Signature	pare						
D)	HMH 17 Rev 1/2	LUUI										

ORIGINAL

#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. N2 0 0 6 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Oct 24, 2006 **Physician** 1315 Twiga Gertrude /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) Examiner Allegany Cumberland Allegany County Nursing Home If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Year) Apr 5, 1913 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1□ M 2√□ F Months Director 214-07-5900 Usual Residence of Decedent 10d. Inside City Limits the Maryland 10a, State 10b. County 10c. City, Town or Location 28a-f show 7 is marked other than "natural", or Nems 23s or 28s-f shot traumatic evant, the Medical Examinar must be notified at 1 No Cumberland MD Allegany Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code permit. Pages 1 and 2 should be filed within 72 hours efter death with t Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 3 any injury or other traumatic evant, the Medical Examinat must be n USA 21502 730 Furnace Street Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S Armed Forces? 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: white 1 ☐ Yes X ☐ No Specify: altimore, Maryland 21215-0020 þ 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) own home homemaker 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Flora Donegan Higgins Joseph Higgins 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) MD 21502 daughter 717 Louisiana Avenue Cumberland Anne Twigg 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 10/28/2000 Cumberland MD Hillcrest Memorial Park 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Scarpelli Funeral Home, P.A. Funeral Service Licensee 108 Virginia Avenue; Cumberland, MD 21502 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) CEREBROVASCULAR ACCIDENT /iviedical **Examiner** Physician/Medical Examiner attending physician end I for use as the buriel-transit or Attending Physicien: The law requires thet the death certificate be exacuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy this certificate hes ral director, page 2 1 ☐ Yes 2 ☐ No 1 🗌 Yes 2 No To the Hospital or Attending Physician: within 24 hours efter death. To the Funeral Director: After this certifica completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient Other: Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ER/Outpatient 3 DOA 1 Yes 2 No Certification: To Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b Time of 28c. Injury at Work? 27. Manner of Death 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 ☐ Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 4 Homicide

Certifying Physician. To the best of my knowledge, death occurred at the time, dath, and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

State

Medical

29a. Certifica

29b. Signature and title of certifier

weno

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MaD Registrar's Signat Mem Hosp Med Bldg Cumberland MD 21502 31. Robustiano, Barrera Registrar

			1 - For State Registrar	State o	f Marylar	nd / Depa <i>Ce</i> a	artment of H rtificate of	lealth <i>Death</i>	and M	ental Hyg	jiene2	006	34933		
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	/Medic	al	WALTER RANI  4a. Facility Name (If not institution,				4b. City, Town, o	r Location		CTOBER	17	2006 ounty of Death	7:18 A M		
	Examir	er	HARFORD MEMORIAL		,				GRACE	Ξ	40.00	HARF	ORD		
	Funeral Director		228-72-8325	Sex X⊒M 2□F	7. Age (In yrs. 58	last birthday) Yrs.	If Under 1 Year Months Days	If Unde Hours	Min.	8. Date of Birth (Month, Day SEPT 3,	1948	Cou	place (State or Foreign ntry) [RGINIA		
	ow I		Usual Residence of Decedent  10a. State 10b. County		10c. Ci	ty, Town or Lo	ocation					T.	10d. Inside City Limits		
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926	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelth and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-1 ehow any injury or other traumatic event, i'm Medical Exartmar must be rightled at ance.	by	1 ☐ Never Married 2 ☐ Marrie 3 ☐ Widowed 4 ▓ Divorced	If Yas, Gi	2 🗆 No		If Yes, specify Cub 1 ☐ Yes 2 No	an, Mexica Specify	an, Puerto F	Rican, etc.)		Black, White,			
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Maryland	12 sho h and 7 is m		19a. Informant's Name/Relationship				ng Address (Street								
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Baltimore,	permit. Departn Imports any Inju		21. Signature of Funeral Service Li	censee	0		2. Name and Addre	ss of Faci	lity						
	20E = 9		LISA SCOTT FUNERAL HOME, P.A. 552 LEWIS STREET, HAVRE DE GRACE,												
	Dharistan		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. firmediate Cause (Final												
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	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate hes completely filled in by the funeral director, page 2	Med	29b. Signature and title of certifier	and man	stated.		29c. Licens	e number		2	9d. Date s	igned (Month,	Dey, Year)		
)			> Whan	mo			13	2600	3	ioliswa					
6	HIVA		30. Name and address of person w	no completed caus	se of death (fter	n 23a) (Type,	Print)	Que	e Na (	Corner	un a	1074			
1.5	Sta	te	31. Date fifed (Month, Day, Year)	3/F	Registrar's Sign	ture	tion St F	300.7	C De I	grace r	א כמי-	1015			
	Registr		NCT 2 0 2	UU5 100	due L	The Alph									

WALTER TURNER

Baltimore, Maryland 21215-0036

**Funeral** 

Director

other traumatic event, the Mudical Examiner must be notified at

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permit. Pages I and 2 should be flied wit Depertment of Health and Mantal Hygiene Important: If Item 27 Is marked other the any Injury or other traumatic event, Ins.) onca.

**Physician** 

Examiner

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The law requires thet the death certificate be executed

certificate

Hospital or Attending Physicien: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director.

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Box 68760

Division of Vital Records, P.O.

/Medical

or Iteme 23a or

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1- For amend #8 Per Phy G861 11/08/06 The Registrar Registrar Registrar Registrar Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Vaar **Physician** Pierre Andrew Townsend Jr. actuber 16 2006 2000 PM /Medical Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 5. Social Security Number HICATIO SALISBURY Medical If Under 1 Year | If Under 24 Hrs. 4 Hrs. 8. Date of Birth
Miny Oct 16, 2006 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Months 1 DM 2 □ F Maryland Usual Residence of Decedent 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits 1 XYes 2 No Princess Anne Director Maryland Somerset 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 21853 USA 11469 Bratten Ave. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White fican/ ☐Yes 2 ☐XNo Yes, Give 1 X Never Married 2 ☐ Married 1 Yes 2 No Specify: Specify: American Completed by 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) n/a n/a 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Kayla Ja'Tia Kindle Pierre Andrew Townsend Sr. ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PO Box 92, Princess Anne, MD 21853 Kayla J. Kindle/mother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10/18/06 Salisbury, MD Salisbury Crematory 22. Name and Address of Facility Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 Signature of Funeral Service Licensee and H. 23a. Part 1. Enter the disease, or confolications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) extreme rematurit Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month 4☐Pregnant at time of death 5 ☐ Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Be Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 2 \ No 1 Yes 2√No 1 Tyes 25. Was case referred to medical 26. Place of Death (Check only one) axaminer' Other 1 ☐ Yes 2 No 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1. Natural 2 Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai 2 | Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Grieck only one)

State Registrar

atherine 100 E. Carroll. 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

otherne

St. Salisbury MD 32 Registrar's Signature DOT 19 2006

29c. License number

29d. Date signed (Month, Day, Year)

Division of Vital Records, 24 hours within 24 hou To the Funa completely file To the

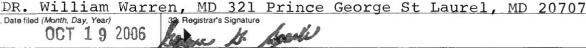
Box 68760.

P.O. |

State Registrar 29b. Signature

32 Registrar's Signature 31. Date filed (Month, Day, Year) 19 2006 OCT

and address of person who completed cause of death (Item 23a) (Type, Print)



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29c. License number

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29d. Date signed (Month, Dey, Year)

October 10, 2006

### ់06-0801**ង** Winfield Chamberlain Towles

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State of Mar	ryland / Departr	ment of Health a	ind Mental Hygien

		1- For State Registrar	C	ertificate d	of Death		Reg.	No. 200	6 31.036
Physicia	an/	1. De œdent's Name (First, Middle,I	_ast)				Date of Death     Month	av Year	3. Time of Death
Medical Exami	ner	Winfield Chamb 4a. Facility Name (if not institution,		S	4b. City, Town, or	Leasting of Death	October 25,	2006 4c. County of Deat	1022 hrs
		7610 Lynn Drive	give street and number/		Chevy Chas			Montgomery	n
Funeral	_	Social Security Number 6.	. Sex 7. Age (In yr:	s. last birthday)	If Under 1 Year	If Under 24Hrs	. 8. Date of Birth (	MM/DD/YYYY) 9. Bi	rthplace (State or Foreign
Director		247-80-3163	1 X M 2 F	60 Y	Months Days	Hours Min.	MAY 31,	1946 SC	ountry)
		Usual Residence of Decedent			l,l				
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Maryland 28a-f show d at ouce.	ţ	Maryland Montgo  10e Street and Number	mery C	Chevy Ch	ase 10f Zip Code		140	0.1	1 Yes 2 No
e Mar or 28s	Director							Citizen of What Cou	
eath with the Maryland items 23a or 28a-f sho ust be notified at once.		7610 Lynn Drive 11. Marital Status	12. Was Decedent Ever in	1 U.S. 13. W	20814 /as Decedent of His			United Sta	ates rican Indian, Black,
death wor items	Funeral	1 Never Married 2 Marr	Armed Forces?	If	Yes, specify Cuban			White, etc.	
hours after death 'natural", or iten Examiner must 1	by F	3 Widowed 4 X Divord	ced If Yes, Give Year or Dates: 1974-19	76	Yes 2 X No			Specify: Wh	nite
hours natur Exam	ed	15. Decedent's Education (Specify			ent's Usual Occupati most of working life.			6b. Kind of Business	Industry
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21215-0036 hould be filed within 72 hours affice and Mental Hygiene is marked other than "natural", tife event, the Medical Examiner	a	Louis	Towle			Louis		Miller	
D 2121 should be f and Mental 7 is marked natic event,	ဥ	19a. Informant's Name/Relationship	(Type, Print)	19b. Mailii	ng Address (Street	t and Number or F	Rural Route Numbe	r, City or Town, State	e, Zıp Code)
ore, MD ss 1 and 2 sho of Health and If item 27 is her traumati		Cordes C. Towles 20a Method of Disposition	./Son	400W	. 194th S	t. #5 N		NY 1003  Oc Location - City or	
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Balti Permit Departit Import		In // Mey	M0095	6 93	Name and Address	Mortuary	Service,	P.A. Spring, MD	20910
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/Medical Examiner		Immediate Cause (Final disease	a. Atheroscleroti	c cardiov	ascular dis	ease			Between Onset and Death
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760, ficate being physicia the buria	/Me	IF FEMALE. 23b, Was decedent pregnant in the	23c. If yes, outcome of pr	egnancy			,	23d Date of deliver	y
certification of the second of	ian	past 12 months?	1 Live birth Pregnant at time of	death		Ectopic pregna	ncy .	Month	Day Year
Box 687 he death certiff the attending	Physic	1 Yes 2 No 9 Unkno		3 (	Other (Specify)		1		
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Sion of Attending Pl r death. ector: After	ertification:	1 X Natural 5 Pending	(Month, Day, Year)	200. 11110 01		es 2 No	Zod. Describe now	injury occurred	
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Divis Hospital or A 24 hours after Funeral Dire	E	4 Homicide determi					or Town, State	e)	Į.
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To the Hos within 24 h To the Fur completely	edical		ner: On the basis of examination and manner stated.	n and/or investiga					
1-VA	Σ	29b. Signature and title of certifier	101		29c License			9d. Date signed (Mo	
		Thurdon,	M. Kind	Thym.	0.C.N	/I.E.	(	October 26, 200	0
		30 Name and address of person when Theodore M. King, Jr., N.			111 Penn Str	eet. Baltimore	e. MD 21201		
St	ate	24 Data filed (14 - (1 D - 14 - 1		4	ale)		-, = 1201		
Regist		OCT 27	2006 32 Registrar's Sign	A. P. P. M.	136-1				

State of Maryland / Department of Health and Mental Hygien ? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 7:45 pm M Sheri Lee Wahl. October 24. 2006 7 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Memorial Hospital Frederick Frederick If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. April 4, Year 1962 5. Social Security Number 7. Age (In yrs. last birthday) 6 Sex 9. Birthplace (State or Foreign **Funeral** 217-86-1720 1 M 2 VF Mary land 44 Yrs Director Usual Residence of Decedent 10b. County 10c. City. Town or Location 10d. Inside City Limits 10a. State rthan "natural", or iteme 23a or 28a-f show the Medical Examiner must be notified at Maryland Frederick Frederick 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5813 Bells Lane U.S.A. 21704 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White 2 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry at Hygiene. Elementary/Secondary (0-12) 12 College (1-4or 5+) Homemaker Own Home permit. Pages 1 and 2 should be filed Department of Heelth and Mental Hyg Importent: If Item 27 le marked othe any injury or other traumatic event, 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Lawrence Carlton Mills Eleanor Fox ٩ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James Christopher Wahl, Sr., Husband 5813 Bells Lane, Frederick, MD 21704 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition
1 □ Burial 22 □ Cremation 3 □ Removal from State Date 20c. Location - City or Town, State Smithsburg Crematory Oct. 26, 2006 4 Donation 5 Other (Specify) Frederick, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Faculity Keeney and Basford PA Funeral Home MO0255 106 East Church St., Frederick, MD 21701 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Metabolic Acidosis - Severe 30 Hours /Medical Due to (or as a consequence of) Examiner Hypovolemic Shock Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 3 Ectopic pregnancy cete has been signed by the atterpage 2 should be detached for in the past 12 months?
1 Yes 2X No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ۵ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a. Was an certificete has 1 Yes 2 □ No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 The Impatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1X Yes 2 No 2 ☐ ER/Outpatient 3 ☐ DOA 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: After Injury 1 X Natural 5 Pending al or Attendir s efter death. I Director: Af To the Hospital or Attendit within 24 hours effer death. To the Funeral Director: A completely fitted in by the fu 1 ☐ Yes 2 ☐ No investigation 2 ☐ Accident 6 ☐ Could not be 28t. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of fnjury - At home, farm, street, factory, office building, etc. (Specify) determined 4 \ Homicide 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D26609 Sz October 24, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 56 Thomas Johnson Drive, Frederick, Maryland 21702
32 Registrars Signature Joseph Ashwal, M.D., Vear) 2006 State Registrar

			For State Registrar	S	tate of M	larylan		artmen rtificat			ind M	ental Hy	giene	$2  \mathrm{n}$	06	349	38
	Physici		1. Decedent's Name (First, Middle	e, Last)		l	WIL	SU	N			2. Date of De	Day	4	Year	3. Time of De	_ /
	/Medic Examin		4a. Fecility Name (If not institution 1706 Bargers R	-	et and number	)	-	4b. City,		Location o					y of Death Arun	del	
	Funeral Director		5. Social Security Number 219-28-2090	6. Sex 1 ☐ M	2 F 7. A	ge (In yrs.	1ast birthday) 78 Yrs.	If Under Months	1 Year Days	If Under a	24 Hrs. Min.	8. Date of Bir Month Da Mar 28	th ly, Year	28	9. Birthp Maryl	lace (State or F Pland	Foreign
	Maryland	tor	Usuel Residence of Decedent           10a. State         10b. County           MD         Anne	Arun	del		y,TownorLo		-						1	0d. Inside City	
	with the	i Dire	10e. Street and Number 1706 Bargers R	oad				10f. Zip 210					_		What Cour State	•	
336	ges 1 end 2 should be filed within 72 hours after death with the Maryland it of Heelih and Mental Hygiene. If I tem 27 is marked other than "natural", or Iteme 23a or 28a-f show or other traumatic event, the Medical Endither must be inclided at or other traumatic event, the Medical Endither must be inclided at	by Funeral Director	11. Marital Status  1 Never Married 2 Mar  3 Widowed 4 Divorces	12.	Was Deceden Armed Forces 1  Yes 2 Il Yes, Give Year or Dates	? KNO		Was Deced If Yes, spec		spanic Orig n, Mexican Specify:	gin? (Spe , Puerto	cify Yes or No Rican, etc.)	)-	Bla	ce - Americ ack, White,		
Maryland 21215-0036	filed within 72 hor Hygiene. other then "naturi ent, ine Medicali	Completed	15. Deceder (Specify only highe Elementary/Secondary (0-12)	st grade co		5+)	(Give	dent's Usua kind of wor DO NOT us odian	al Occupa rk done d se retired	ation during most )	of worki	ng			Business/Ind Gover		
/land	2 should be filed and Mental Hygie Is marked other sumatic event, III	To Be C	17. Father's Name (First, Middle, John Howard	Last)						18. Mothe Anni		(First, Middle, dwards	, Maiden	Suma	me)		
	1 end 2 sho Heelth and I sm 27 is mu		19a. Informant's Name/Relations Darlene Wilson									Route Numb rills,				Code)	
Baltimore,	nit. Pages 1 e certment of He- certant: If Itsm injury or other		20a. Method of Disposition  1 28urial 2 Cremation 4 Donation 5 Other (S		oval from State		Place of Dispo emetery, cre .1son (	natory or o	ther plac	e)		oct 20 2006			·City or To		
Balt	permit. Page Depertment o Important: If any injury or once.		21. Sunature of June al Service	Licerse	H	-	2:	M11118 1922	d Address Fore	Metro est Di	poli rive	tan Ch Annap	apel olis	, M	ID		- 1
	Physician /Medical		23a. Part1. Enter the disease, o shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	complicati only one c	ause on each	line.	Stag	er the mod	e of dying	g, such as	far da	r respiratory a	rrest,			Approximate Interval Betwe Onset and De	en nth
	ate be executed hysicien and hysicien and hite burial-transit and	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last	b c	Due to (or a	s a conseq	uence of):	Ky P.	ei	fe	us	in				yla	-
. Box 68760,	as l	Physician/Medical E	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ ∀es 2 ☑ No		If yes, outcom 1 □ Live birth 4 □ Pregnant :	2 Feta	Ideath 3[	Ectopic pr							ate of delive	ery Day Yea	ar
ds, P.O.	uires that the death cer signed by the ettendin d be detached for use	þ	9 ☐ Unknown  Part II. Other significant conditi			but not res	ulting in the u	nderlying c	ause give	en in Part I.			obacco u Yes 2		ntribute to th	ne cause of dea	
		Completed										24a. Was auto perfo		24b.	prior to condeath?	psy findings ava mpletion of caus	arlable se of
Vital	Physiclen: Th this certificete ral director, pag	To Be (	25. Was case referred to medica examiner? 1 ☐ Yes 2 ☑ No	Hosp	oital: 1 ☐ Inpat	ient 2 🗆	ER/Outpaties	nt 3 DC	A Othe	ac .	of Death	ne 5 A Aesi		6 🗆 Ot	her (Specifi	y)	
			27. Manner of Death  1 Atturel 5 Pendi	ng	28a. Date of In (Month, D	ury ay Year)	28b. Time o Injury	f M	Bc. Injun	rat k? Yes 2 ∐ !		28d. Describe	how injui	у осси	rred		
Division	To the Hospital or Attending within 24 hours efter death. To the Funeral Director: After completely filled in by the fune	Certification:	3 Suicide 6 Could 4 Homicide determ	not be	8e. Pface of Ir building, 6	njury - At ho atc. (Specif	ome, farm, st	reet, factory	, office		1	28f. Location ( City or To			iber or Rura	l Route Numbe	)r,
	To the Hospital or At within 24 hours efter of To the Funeral Direct completely filled in by	Medicai C	(Check only one)	ng Physici Examiner:	On the basis and manner s	of examina	wladge, deat tion and/or in	n uncerted vestigation	at the tin , in my or	ie, date and pinion, deal	d place, t	and due to the ed at the time,	cauca(s) date and	and it place	and due to	ated. the cause(s)	i
)	To the Youth To the comp	Ž	29b. Signature and title of centre	12	He	M	in	290	License	number 2	43	8	29d. Da	e sign	ed (Month,	Day, Year)	
_			30. Name and address of person	gho mp	leted dayse of	death (Item	n 23a) (Type,	Print) 441	DE	EYEN	SE	HigHe	NAG	A	NNA	VU MD	)
	Sta Registi		31. Date filed (Month, Day, Year		32. Regis	trar's Signa	iture	Hor	K				1			2140	)/

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**ORIGINAL** 

			for Stete Registrar	State of Ma	arylan	d / Depa	artmer <i>tificat</i>	t of H	ealth a Death	and M	lental F		ene2 ()	06	34939
	Physici		1. Decedent's Name (First, Middle, La								2. Date of Month		Day	Year	3. Time of Death
	Physici: /Medic		Marie	Long	Wa	aggon					Oct.	12,	2006		5:20 a. M
المم	Examin	er	4a. Facility Name (If not institution, giv 6705 96th Avenue				Lank	nam	Location o				4c. Count		orges
	Funeral Director		5. Social Security Number 6. S 535–14–0205  Usual Residence of Decedent		97	ast birthday) Yrs.	If Unde Months	1 Year Days	If Under a	Min.	8. Date of (Month, Aug.	Day, Y	1909	Cou	place (State or Foreign ntry) fornia
	be filed within 72 hours after deeth with the Maryland ital Hyglene. d other than "ratural", or Iteme 23a or 28a-f show event, the Madical Examinar must be collified at	Funeral Director	10a. State 10b. County MD Prince G  10e. Street and Number 6705 96th Avenue  11. Marital Status  1 □ Never Married 2 □ Married	eorges  12. Was Decedent Amed Forces? 1   Yes 2   1	Lan		10f. Zi <sub>l</sub>		spanic Ori	gin? (Spe	ecity Yes or Rican, etc.)	Un		What Cou State	can Indian,
Maryland 21215-0036	n 72 hours af "natural", or adical Ezam	Completed by F	3 Widowed 4 □ Divorced  15. Decedent's E (Specify only highest gr.	If Yes, Give Year or Dates: ducation		16a. Deced	1 ☐ Yes tent's Usu kind of wo	al Occupa	furina most	t of worki	ng	16	Special Specia	fy: Whi	
7	withir ene.	Ę.	Elementary/Secondary (0-12)	College (1-4or 5	i+)	Homem		35 / 51// 00	,			o	wn Ho	me	
land 2	0 2 0	To Be Co	17. Father's Name (First, Middle, Last Charles Long	)		1201110411					(First, Mid	dle, Ma	iden Sumai		
Mary	id 2 shou Ith and M 27 is mar traumat		19a. Informant's Name/Relationship ( Dana Waggoner-Ger		er)	1	•	•					City or Town		p Code)
Baltimore,	permit. Pages 1 and 2 should Depertment of Health and Men Important: If Item 27 is marke eny Injury or other traumatic 9008.		20a. Method of Disposition  1 Burial 2 Cremation 3  4 Donation 5 Other (Specie	Removat from State	20b. P	lace of Dispo emetery, crer	sition (Na	me of other plac		ctober 2006	r 13,	20	c. Location	- City or T	
Baltii	permit. F Depertmol Importar eny Injur		21. Signature of Fureral Service Lice	nsee	10098	22	. Name a	nd Addres		yAdve	nt Fune		& Crem , Maryl		Service 401
8760,	Physician //Medical Examiner  thysicien and physicien and the pontar-transit	dical Examiner	23a. Part1. Enter the disease, or comshock, or heart failure. List only timmediate Cause (Finat disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as  c. Due to (or as  d. Due to (or as	ne. DVASC a consequ a consequ	rular Duence of):			g, such as	cargiac	rrespirator	y arres			Approximate Interval Between Onset and Death
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	luires thet n signed b uld be deta	þ	Part II. Other significant conditions	contributing to death b	ut not resi	ulting in the u	nderlying	cause give	en in Part I.			7	cco use cor 2 □ No	tribute to	the cause of death?
Recoi	The law requires thet the ate hes been signed by th bage 2 should be detache	Completed										utopsy erforme		Were aut prior to co death? 1 \( \text{Yes} \)	opsy findings avaitable ompletion of cause of 2□ No
ita	icien: Th certificate ector, pag	Be (	25. Was case referred to medical examiner?						26. Place	of Death	n (Check on	ly one)			
Division of Vital Records,	ding Phys h. After this funeral dii	၉	1 ☐ Yes 2X No  27. Manner of Death  1 X Naturat 5 ☐ Pending 2 ☐ Accident investigation	Hospital: 1 ☐ Inpatie  28a. Date of Inju (Month, Da	iry	ER/Outpatier 28b. Time o Injury		28c. Injun World	4 🗆 190				ce 6 ⊡Ot injury occu		fy)
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	To the Hospital or Atten within 24 hours efter deat To the Funerel Director: completely filled in by the	edical	(Check only 2 Medical Exa	hysician: To the best miner: On the basis o and manner st	f examina		vestigatio	n, in my o	pinion, dea			ne, date	e and place	, and due	to the cause(s)
	To To corr	Σ	29b. Signature and title of certifier	- Olle	28	W		D 23					n. Date sign ctober		. <i>Day, Year)</i> 2006
			30. Name and address of person who Martin Weltz, M.I	D. 7525 Gre	eenwa	y Cent		rive	Gree	enbe.	lt, MI	0. 2	21044		
	Sta Registi		31. Date filed (Month, Day, Year)  OCT 1 8 2	32 Registr		ture	alle	,							

34940 State of Maryland / Department of Health and Mental Hygien [] [] [ For State Registra Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Yeer Month **Physician**  $A^{\mathsf{M}}$ 2006 October 13 4:15 Marjorie Ann Wetzel /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4h. City. Town, or Location of Death Examiner Carroll 4545 Hickory Lane Mount Airy If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months 1 ☐ M 2 🗓 F 212-36-9322 70 May 24, 1936 Maryland Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. Count rthan "neture!; or items 23s or 28s-f ehow the Medical Examiner must be nutified at 1 ☐ Yes 2 ☑ No Mount Airy Carrol1 Maryland Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21771 United States 4545 Hickory Lane Funeral filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: δ 3 ☐ Widowed 4 ☑ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) 5+ Teacher Public Schools other 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if item 27 is marked oth any injury or other traumatic event 9068. 17. Father's Name (First, Middle, Last) Be Dorothy Amanda Nikirk Arthur Roby Hardy 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Mt. Airy, Maryland 21771 4006 Lomar Drive Maureen Zelinsky / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition October 0 1 ⊠Burial 2 ☐ Cremation 3 ☐ Removal from State Pine Grove Cemetery 17, 2006 Mt. Airy, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Stauffer Funeral Homes, P.A. 21. Signature of Funeral Service Licensee 8 E. kidgeville blvd. Mr. Airy, Maryland 21771 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Years Atherosclerotic Cardiovascular Disease disease or condition resulting in death) /Medical Due to (or as e consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury b Due to (or as a consequence of): Examine attending physicien and for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physiclan/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23h Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 🖾 No the 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 9 1 Yes 2 No 3 Probably 4 Unknown Hypertension peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No 24a. Was an has autopsy performed? page 2 1 Yes 2 No director. Be 25. Was case referred to medical 26. Place of Death |Check only one| Hospital: 1 Inpatient Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) 1 ☐ Yes 2 🗓 No 2 ER/Outpatient 3 DOA ို this ieral Director: After the 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: or Attending Injury 1 X Natural 5 Pending death. 1 Yes 2 No investigation 2 Accident 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours after To the Funeral Dire o the Hospitel 29a. Certifier 1 🔯 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D37197 October 16, 2006 lun 30. Name and address of person who completed cause of death (Ilem 23a) (Type, Print) 15 W. Seventh Street Frederick, Maryland 21701 Alan Rohrer, M.D. 32. Registal's Signature 31 Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

State

Registrar

OCT 1 9 2006 >

		1	For Stata Registrar	State of Mar	ryland /		rtment of H tificate of L			giene 0	06	34941
4	11.27	7	1. Decedent's Name (First, Middle, Last)						2. Date of De. Month	ath Day	Year	3. Time of Death
	Physicia /Medic		JUSTIN TYI	LER WALSH						11 200		3:14 A M
	Examin		4a. Facility Name (If not institution, give s		Mari			Location of Death	1	4c. Cour	MONTE	
			NATIONAL NAVAL 1  5. Social Security Number 6. Sex		INTEK (In yrs. last	hirthday)	If Under 1 Year	ESDA If Under 24 Hrs.	8. Date of Bir	th	9. Birth	GOMERY  uplace (State or Foreign
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			Usual Residence of Decedent			-			, , , , , ,			
	nylani ihow		10a. State 10b. County		10c. City, T	own or Loc	cation				100	10d. Inside City Limits 1 √2 Yes 2 □ No
	Ba-f	cto	OH PORTAG	E	DE	ERFII						71
	or 21	Director	10e. Street and Number				10f. Zip Code	1		10g. Citizen		
	death with the Maryland ms 23s or 28s-f ehow r must be notified at	rai	10610 KIRK DRIVE	12. Was Decedent Ev	var in 11 S	13 V	4441		necify Yes or No			STATES rican Indian,
36	be filed within 72 hours after death with the Marylan tal Hygiene d other than "natural", or Itema 23a or 28a-f show event, the Medical Examinar must be notified at	by Funerai	11. Marital Status  1 X Never Married 2 ☐ Marned 3 ☐ Widowed 4 ☐ Divorced	Armed Forces?  1 X Yes 2 □ No If Yes, Give Year or Dates: 2	)	1	Vas Decedent of H Yes, specify Cuba	n, Mexican, Puert Specify:	o Rican, etc.)		Black, White	
Maryland 21215-0036	2 hou		15. Decedent's Educ	cation		6a. Deced	ent's Usual Occup	ation	dun a	16b. Kind of	Business/l	Industry
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<u>ya</u>	should be and Mental marked o umatic eve	မ	JAMES L. WALSH						TH CARS		- 0 7	To Contain
<u>a</u>	2 42 48		19a. Informant's Name/Relationship (Ty) TERI BETH WALSH/MO				g Address (Street and BOX 432				vn, State, Z	Ip Code)
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Baltimore,	permit. Pages Department of I Important: If Ite any Injury or o'		1 DBurial 2 Cremation 3 R	emoval from State	cem	etery, cren	natory`or other plac NAT <sup>†</sup> L . (		24_2006	ARLIN	CTON	77 A
	artme ortani Injury		4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service License	90 0	AKLII				the same of the sa			
Ba	Dep Impo		Mall Cham		M <b>00</b> 09	L C 5	Name and Addre HAMBERS 1 801 CLEVI	FUNERAL E ELAND <b>A</b> VI	HOME & C E., RIVE	REMATO RDALE,	MD.	20737
			23a. Part1. Enter the disease, or complishock, or heart failure. List only or	cations that caused t	the death.							Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition			S DIIF	TO BLAS	T TNJURT	ES			Onset and Death
R	/Medical		resulting in death)	Due to (or as a			TO DILLE	I IIIO GRE				
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927	be sit	iner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (cr as a	. consequer	ice of):						
	cate be executed physicien and the burial-transit	Examiner	that initiated events resulting in death) Last	Due to (or as a	consequer	ice of):						
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687	ficate p physics the	edicai										
.O. Box	The law requires that the death certificate be executed ate has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome o 1 □ Live birth 2 4 □ Pregnant at t 9 □ Unknown	2 ☐ Fetal de	ath 3	Ectopic pregnancy Other (specify)	/			Date of deli Month	ivery Day Year
۵.	res that tigned by	H.	Part II. Other significant conditions con	stributing to death but	t not resulti	ng in the u	nderlying cause giv	en in Part I.	23e. Did	tobacco use c	ontribute to	the cause of death?
ds	uires sign ld be	d by							1 🗆	Yes 21 No	3 ☐ Pr	obably 4 Unknown
Records,	w requir	Completed							24a. Was		b. Were au	utopsy findings available
	The lav	E O							auto perfe 1 XYes	ormed?	death?	completion of cause of
Vita	icien: Th certificate rector, pag	O O	25. Was case referred to medical		_			26. Place of De	ath Check only	-	-7A	
$\geq$	Physicien: this certificantal director,	To B	examiner?  Yes 2 No	lospital: 1 🗓 Inpatien	nt 2□EF	VOutpatier	nt 3 DOA Oth	ler: 4 ☐ Nursing }	Home 5□Res	idence 6 🗆	Other (Spec	city)
Division of	D je je	Certification;	27. Manner of Death 1 □Natural 5 □ Pending 2 □ Accident investigation	28a. Date of Injury (Month, Day OCT 5	Year)	3b. Time of Injury 092	Wo	yat rk? Yes 2 □ No	28d. Describe		curred	
N N	r Atte	tific	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injurious building, etc.		e, farm, str	eet, factory, office			(Street and Nu wn, State)	ımber or Ru	ural Route Number,
ō	itel or A rs after ral Dire led in by	Cer	**	1			L QAIMR			IRAQ		
	To the Hospitel or Attendir within 24 hours after death. To the Funeral Director: Af	Medical	29a. Certifier 1 Certifying Phy (Check only one)	sician: To the best of ner: On the basis of and manner stat	examination	edge, deat n and/or in	h occurred at the til vestigation, in my o	me, date and place opinion, death occ	e, and due to the urred at the time.	cause(s) and date and place	manner as ce, and due	stated. Ito the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	2			29c. Licens	se number		29d. Date sig	gned (Monti	h, Day, Year)
0	1+1		1 Jan X	<i>&gt;</i>		MD	MD-1	13283 (HI	(1)	OCT	11 200	06
0	ti.		30. Name and address of pulson who co	ompleted cause of de	eath (Item 2	За) (Туре,		ED FORCES		UTE OF	PATHO	OLOGY
				20 Demistre	JSA			VILLE ME	20858			
	Sta Regist		31. Date filed (Month, Day, Year) OCT 18 206	3 Registra	r s Signatur	Los	de					

			1 - State Registrar	State of Maryland		artment of H		Mental Hy	gien <b>e</b> Reg. No.	006	34942	
			Decedent's Name (First, Middle, Last)	1				2. Date of D	aath		3. Time of Death	1
	Physicia	an						Month	Day	2006	02:20 N	
	/Medic Examin		Diane Kathryn Wil  4a. Facility Name (If not institution, give		1	4b. City, Town, o	or Location of Dea	1 100	4c.	County of Death		_
	Examin	er				77			Wa	shinoto	on County	
4.	Funeral		Washington County 5. Social Security Number 6. Sec	HOSPITAL 7. Age (In yrs. last	birthday)	Hagersto			rth	9. Birth	place (State or Foreig	n
	Director		200-34-8644	M 2∰F 62	Yrs.	Months Days	Hours Min	. (Month, D 8-9-19			uintry) islyvania	
			Usual Residence of Decedent									
-	ehow	.	10a. State 10b. County	10c. City, T	own or Lo	cation					10d. Inside City Limits 1 ☐ Yes 2 ☐ No.	
:	a-f-	Director	Maryland Washingto	on County Hage:	rstow	n					1 Tes 2 N	۵
	5 28 ⊞	ire	10e. Street and Number			10f. Zip Code			10g. Citi	zen of What Co	untry?	
	death with the Maryland me 23a or 28a-f ehow mest be notified at	a	12902 Cathedral Ave	e		21742			U.S.			
-	dea m	Funerai	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. \	Was Decedent of H	Hispanic Origin? ( an, Mexican, Pue	Specify Yes or N rto Rican, etc.)	0-	<ol> <li>Race - American Black, White</li> </ol>		
و ،	or it		1 Never Married 2 Married	1 ☐ Yes 2 🛣 No If Yes, Give		I□Yes 2∰ No				Specify: Wh	ite	
9500-G	within 72 hours after ene. than "naturel", or Ite he Wedical Examine	d by	3 Widowed 4 Divorced	Year or Dates:					1			
ភ្ន	72 t	Completed	15. Decedent's Edu (Specify only highest grad		(Give	lent's Usual Occup kind of work done DO NOT use retire	during most of we	orking	16b. Ki	nd of Business/	Industry	
7	han o	g E	Elementary/Secondary (0-12)	College (1-4or 5+)					Fod	oral Go	vernment	
N.	e filed within 72 hours after death with the Maryla all Hygiene 13a or 28a-f ehov to the than "naturel", or iteme 23a or 28a-f ehov vent, the Madical Examiner must be notified at		17. Father's Name (First, Middle, Last)	31 (	11n1C	al_Pharm		ame (First, Middle	1		VCITIMETTE	
⊆ .	D = 0 =	Be	Stiney Albert Mas	aitis			Kathry		Yasen			
<b>5</b>	natic	T <sub>0</sub>	19a. Informant's Name/Relationship (T)		10h Mailin	ng Address (Street					in Code)	
Z Z	h and h and 7 le n Ireun		Terry Wills/Husban			2 Cathedr						
	t Healt them 2 tother		20a. Method of Disposition			sition (Name of	di nve.	Date		cation - City or		_
٥	00		1 ☐ Burial 2 ☐ Cremation 3 ☐ F	Removal from State	etery, cren	natory or other pla g Cremat		-24-06			Maryland	
	t. Pag tment tant: tant:		4 □Donation 5 □ Other (Specify)			_					eral Home	_
Baltimore,	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service Licens	99		331 Easte						
_	40244	/	23a. Part1. Enter the disease, or comp	Zury						,110 2171	Approximate	
			shock, or heart failure. List only of	ne cause on each line.	Do not ent	er the mode of dyl	1 ^	ac or respiratory	arrest,		Interval Between Onset and Death	
F	nysician		Immediate Cause (Final disease or condition	a DIASMACYTO	MA	- K19	(17)	evvis			WEEKS	
	/Medical Examiner		resulting in death)	Due to (or as a contequen	ce of):	10/100	1				In FELCE	
	LAUIIIIII	L	Sequentially list conditions,	b. The Carlotte	1114	16101111	7				MICERI	_
	sit ad	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a cons	1 - 1	102E					LIFELC	
	end end I-tran	Examine	that initiated events resulting in death) Last	c. Due to (or as a consequen	ice of):	VICL					WLLKS	-
8760,	The law requires that the death certificate be executed the hes been signed by the attending physician end rage 2 should be detached for use as the burial-transit			CFOSIS-	111	1017	NSIGN	7			DAUS	
8	physi the t	dicai		d. 32 100		11010	101101				1111	
×	leath certific attending pl	Completed by Physician/Me	IF FEMALE:	23c. If yes, outcome of pregnancy	,					23d. Date of del	ivery	
Box	atten atten for u	ian	in the past 12 months?	1 Live birth 2 ☐ Fetal de 4 ☐ Pregnant at time of deat	ath 3	Ectopic pregnand Other (specify)	;y			Month	Day Year	
o.	the d	ysic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	9□ Unknown		g out of (opcomy)						
من	res that the de signed by the a be detached f	F.	Part II. Other significant conditions co	ntributing to death but not resulting	ng in the u	nderlying cause gr	ven in Part I.	23e. Did	tobacco u	ise contribute to	the cause of death?	
g,	sign d be	9	MET	ABULIC ACI	005	16		1	Yes 2	⊠No 3□Pr	obably 4 Unknow	m
Š	w require been si should b	ete	, , , ,					24a. Wa		24h Ware 2	itopsy findings availab	
ĕ	hes hes	ig.					-	aut	opsy formed?	prior to death?	completion of cause of	
<u></u>								1 ☐ Yes	2 1 No	1 Yes	2□ No	
=	siciar certif recto	Be	25. Was case referred medical examiner?	Hospital:	1/0 1-11	Ot	her	eath (Check only		• Flow - 10		
ō	> .92 0	2	1 Yes 2 No		VOutpatier b. Time o	IL 3L DOA	4 Li Nursing	Home 5 Res			city)	
5	ding After fune	ē	1  atural 5  Pending 2  Accident investigation	28a. Date of Injury (Month, Day Year)	Injury	f 28c. Inju	ork? ]Yes 2. □No					
Division of Vital Records,	Attending Physician: If death. Sector: After this certification in the funeral director.	fica	3 Suicide 6 Could not be		e, farm, str	reet, factory, office					ıral Route Number,	-5
	- 9	Certification;	4 Homicide	building, etc. (Specify)		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		City or To	own, State	)		
_	To the Hospital or Attending Ph within Z th bours after death. To the Funeral Director: After th completely filled in by the funeral		29a. Certifier 1 Certifying Phy	vsician: To the best of my knowle	edge, deat	h occurred at the t	ime, date and pla	ce, and due to the	e cause(s)	and manner as	stated.	_
	P Ho	Medicai		iner: On the basis of examination and manner stated.								
	To th within Fo th compl	Me	29b. Signature and title of certifier			29c. Licen	se number		29d. Da	te signed (Mont.	h. Day, Year)	
			> Call Mical	11 // cons-	2	1)0	10220L	13		10-24	-06	
			30. Name and address of person who	ompleted cause of death (Item 2	3a) (Type;	Print)	•			1 1 0	~	
51	1-10		IIIIO MEDI	CA/ CAMO	YK	(1) It	AGER1	7000 N	1	11) 2	1742	
	Sta	ate	31. Date filed (Month, Day, Year)	32. Registrar's Signatur	6	,	1			· · · · · · · · · · · · · · · · · · ·		
	Regist		UCI 242	006 Breen A	1. 1.	neile						

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien [ ] [ ] 5 1 - For State Registrat Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month ACKER **Physician** JR FRANKLIN ROBERT 12=07445 OCTOBER 31 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner UPPER CHESAPERICE MEDICAL CENTER HARFOND BEZATA 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Wonths Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** M 2□F Director July 19, 1960 Maryland 213-80-6691 Usual Residence of Decedent the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a. State 10h County 1 and 2 should be filed within 72 hours after death with the Marylan Health and Mental Hygiene. It was 23 or 28a-f ehow tem 27 is marked other then "natural", or iteme 23a or 28a-f ehow other traumatic event, the Madical Examinas mast be inclified at 1 ☐ Yes 2X No Maryland Harford Abingdon Direct 10g, Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21009 3702 Mill Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married  $|\mathcal{A}|/\mathcal{O}_{\mathcal{C}}$   $|\mathcal{A}\mathcal{O}_{\mathcal{C}}|$  Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: ģ 3 ☐ Widowed 4 ☑ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15 Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) <u>Concrete Finish</u>er Construction 11 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Lou Miller Nancy Robert Franklin Acker, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 s
Depertment of Health ar
important: if item 27 is
any injury or other trau 3702 Mill Road, Abingdon, Maryland 21009 Theodore Acker/ Brother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Dublin Southern Cem. 11-6-06 Darlington, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Faneral Service Licensee 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between 23a, Part1 Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** HASCUD /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner s the here Due to (or as a consequence of): Ackers Robert MSCOH 64815 Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) the 9□ Unknown ģ 23e. Did tobacco use contribute to the cause of death? Part If, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 🗗 Probably 4 ☐ Unknown as been sign 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificete has autopsy performed? 21 No 1 Yes 2 No 1 🗌 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification; To 1 Yes 2 No 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. To the Hospital or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fa investigation 2 ☐ Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide Certifying Physician: To the Sest of my knowledge; death became at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 021809 M - D. OCT 31, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) YOLIC NO TIMONING MO 21093 5. PRASHUM. Q

Registrar

DHMH 17 Rev 1/2001

State

Date filed (Month, Day, Year)

NOV 0 3 2006

2336

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) <u>3:3</u>0 <sup>A™</sup> **Physician** Josephine Trionfo Alloro 02, 2006 November /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Towson Year If Under 24 Hrs. Gilchrist Hospice Center Baltimore Birthplace (State or Foreign Country) If Under 1 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Min. 1 □ M 2 👿 F Yrs. 95 Baltimore, MD 12-18-1910 216-10-9972 Director Usual Residence of Decedent 10d Inside City Limits 10c. City, Town or Location 10a State 10h. County ral", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Baltimore Towson filed within 72 hours after death with the I Hygiene. 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 1116 Green Acre Road 21286 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: White 2 3 X Widowed 4 □ Divorced "natural", Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation the Medical (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) other than Buttonhole Maker Clothing Manufacturing 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be and Mental is marked Joseph Trionfo Alloro Giovanna 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Health i Nancy Cossentina - Sister 1116 Green Acre Road Towson, Maryland 21286 permit. Pages 1 an Department of Healt Important: If Item 2: any injury or other t 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Nother (Specify) Entombment Lorraine Park Cem, 1:
Signators of Funeral Service Licensee harles Miner 22. Name and Address of Facility 6 Gwynn Oak, Maryland 5305 Harford Road 11-06-2006 21. Signatore of Funeral Service Licensee Charles Miner (ha Mines Baltimore, Maryland 21214 Leonard J. Ruck, Inc. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final duodenal ulcer inelles **Physician** erturat disease or condition resulting in death) /Medical Due to (or a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of). attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 □Live birth 2 □ Fetal death
4 □ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year signed by the atte in the past 12 months? 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has 1□ Yes 2☑No 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Other: 4 Nursing Home 5 Residence 6 Dother (Specify) (+v-f) Hospital: 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Division or Vital Records, P.O. il or Attending Pafter death.

Hospital

Director: / 24 hours a

4 Homicide

29a. Certifier

To the I within 2 To the I State

Registrar

Medical

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number November 2, 2006

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

N. Charles St. Balto, Md 2,204

G 6701

32. Registrar's Signature

		•	1 - For State Registrar	State of M	aryland / Dep <i>Ce</i>	artment of F		and Mental H	ygiene Reg. N6	711116	34947
			1. Decedent's Name (First, Middle, La	ast)				2. Date of 0 Month	Death Da	y Year	3. Time of Death
1	Physici /Medic		Barbara Gertrude			T		Novemb		1,2006	9:40 P.M
	Examin	er	4a. Facility Name (If not institution, given 4608 Grave Run Ro		)	4b. City, Town, o	Mille:			County of Deal	
3	Funeval				ge (In yrs. last birthday,	If Under 1 Year	If Under 2	24 Hrs. 8. Date of E	Birth	9. Bir	holace (State or Foreign
	Funeral Director			1□M 2XIF	92 Yrs.	Months Days	Hours	Min. March	14,19	914 Lit	tle Falls,N.J
	pu >		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or L	ocation					10d. Inside City Limits
	aho	ō		Country	Millers	obation					1 ☐ Yes ŽŽ No
	after death with the Marylan or Itsms 23e or 28e-f show intermitation confiled at	Director	Maryland   Carroll  10e. Street and Number	County	MILITELS	10f. Zip Code			10g. Cit	izen of What Co	ountry?
	3a or		4608 Grave Run Ro	ad			21102		Un:	ited Sta	ates
	death	Funerai	11. Marital Status	12. Was Decedent Armed Forces	t Ever in U.S. 13.	Was Decedent of H	dispanic Orig	gin? (Specify Yes or I Puerto Rican, etc.)	No-	14. Race - Ame Black, Whit	
98	hours after death with the Maryland tursi', or Itsms 23e or 28e-1 show at Exame at must be motified at	y Fu	1 Never Married 2 Married	1 Tes 2 1		1 ☐ Yes 2 🖾 No					nite
21215-0036	"naturs!", o	ed by	3 ☑ Widowed 4 □ Divorced  15. Decedent's 8	Year or Dates:	16a Dece	dent's Usual Occup	nation		16b K	ind of Business	
5.	in 72 n "nai	piet	(Specify only highest gr	rade completed)	(Give	kind of work done DO NOT use retire	during most	of working	100.11		,
212	d within giene. or then "	Completed	Elementary/Secondary (0-12)	College (1-4or		Employed	d Chri	stian Writ	er	Wri	ter
pu	be filed ntal Hygie od other svent,	Bec	17. Father's Name (First, Middle, Las	t)				r's Name (First, Midd		Sumame)	
yla	ould be Mental arked c	5	Adrian Orange					rude Orang			
Maryland	s 1 and 2 should ( Health and Mer Item 27 is marke other traumatic		19a. Informant's Name/Relationship			ing Address <i>(Street</i> Shetland		r or Aural Aoute Nun			Zip Code) VID. 21093
-	s 1 and 2 f Health item 27 i		Thomas Bisset (Sc 20a. Method of Disposition	)ri)	20b. Place of Disp	osition (Name of	1	Dilve		ocation - City or	
Baltimore,	permit. Pages 1 a Department of He Important: if item any injury or oth		1 ⊠Burial 2 ☐ Cremation 3 [ 4 ☐ Donation 5 ☐ Other (Spec.		Druid Ri	matory or other pla dge Cemet	ce) cery N	ov.04,2006	Parl	k Heigh	ts,Maryland
Ħ	artme ortan ortan		21. Signature of Funer   Serv & Lice		2	2. Name and Addre	ess of Facility	у	7.		i Chan D A
ä	Dep Imp any		Man Von	6	2	eaceful <i>A</i> 325 York	Road	atiyes fur Timoniun	nerala n, Mai	xCremat: ryland	ion Ctr.,P.A. 21093
			23a. Part1. Enter the disease, or con shock, or heart failure. List only	nolications that cause y one cause on each	d the death. Do not en	ter the mode of dyi	ng, such as	cardiac or respiratory	arrest,		Approximate Interval Between
J.	Physician		Immediate Cause (Final disease or condition	AS	000						Onset and Death
1	/Medical Examiner		resulting in death)	Due to (or as	s a consequence of):	,	1	,			
lie.	×	-	Sequentially list conditions if any, leading to immediate cause. Enter Underlying	b. Due to for as	September of:	Least	tall	ine			Nevita
	15 / 16d	Examine	Cause (Disease or injury	200 (3 (3)	onougusnos on,						
~	te be executed ysicien and X	Exal	that initiated events resulting in death) Last	C. Due to (or as	s a consequence of):						
8760,	death certificate be executed eattending physicien and the for use as the burial-transit	licai		d							
9	rtifica ng ph as th	a	IF FEMALE:						T		
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0	the a	Physician/M	1 ☐ Yes 2 X No 9 ☐ Unknown	4∐Pregnant a 9☐ Unknown	at time of death 5	Other (specify) _					
۵.	law requires that the as been signed by th 2 should be detache		Part II. Other significant conditions	contributing to death	but not resulting in the i	underlying cause giv	ven in Part I.	23e. Di	d tobacco i	use contribute to	the cause of death?
ds,	uires n signi ild be	d by						10	Yes Z	<b>%</b> No 3□P	robably 4 Unknown
Ö	sw requir s been si 2 should	ompieted						24a. W		24b. Were a	utopsy findings available
Re	The age	mo							topsy rformed? : 212 No	death?	completion of cause of
Vital Records,		Be C	25. Was case referred to medical				26. Place	of Death (Check onl			
of V	Physician: this certific	10	examiner? 1 ☐ Yes 💝 No	Hospital: 1 🗆 Inpat		III 3LI DOA		rsing Home 5 Re			ecify)
	ding P. h. After t funera	on:	27. Manner of Death  ↑ Natural 5 ☐ Pending	28a. Date of Inj (Month, D	ay Year) 28b. Time (Injury	Wo		28d. Describ	e how inju	ry occurred	
Division		icat	2 Accident Investigation 3 Suicide 6 Could not	be 290 Place of Ir	njury - At home, farm, si		Yes 2 1		(Street ar	nd Number or R	ural Route Number,
Θį	l or Atten after deat Director; I in by the	Certification;	4 ☐ Homicide determine	building, e	tc. (Specify)	root, lastery, emoc			own, State		
	e Hospital or 24 hours afte e Funeral Dira letely filled in b		29a. Cartiful To Cartifyling F	hysician: To the bes	t of my linewledge, dea	th onnumed at the ti	ma, date an	d place, and due to it	ie causu(s	and manner at	i stated
	within 24 hose To the Furcompletely	edical	(Check only 2 Madical Exa	and manner s	of examination and/or intated.			th occurred at the tim			
	To the within 2 To the complet	Σ	29b. Signature and title of certifier	ſ		29c. Licens	se number	. 0.5	29d. Da	te signed (Mon	in, Day, Year)
	1		marqueil	e Sunai	no	Da	1080C	275	11/00	EmBE	53 300P
	V		30. Name and address person who	completed cause of	death (Item 23a) (Type	, Print)	, 22	td CL .#	25	- Du	HIG ALL A
-	Sta	to.	31. Date filed Month, Day, Year)	32. Regis	trar's Signature	0.0	· 00				no an ad
	Registi		NOV 0 3	2006	ens M	post					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien ? Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Vear **Physician** 1755 PM Kevin Bryant Brown october 29, 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b City Town or Location of Death Examiner Baltimore Hospital of Baltimore Sinai Il Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Min M 2DF Months 39 Yrs. 11/04/1966 MD 213-98-9555 Director Usual Residence of Decedent 10d Inside City Limits 10c. City, Town or Location 10a. State 10b. County 23e or 28a-f ehow the Medical Examiner must be notified at 1 Tyres 2 No Directo Gwynn Oak Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21207 USA 3410 Aurora Lane Apt. 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 "natural", or 1 ☐ Yes 200No Specify: ģ Black 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Bailley's Fitness other than College (1-4or 5+) Elementary/Secondary (0-12) Collections Clerk 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Item 27 is marked oth eny Injury or other traumatic event once. Be Lillian Amos Wi11 Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Deborah Jones/Sister 3410 Aurora Lane Apt. J Gwynn Oak, MD 21207 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Nov 1 1 Burial 2 Cremation 3 Removal from State Beltsville, Maryland Chesapeake Crematory Inc. 2006 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee M0144 Cremation and Funeral Alternatives Rill 8717 Green Pastures Drive Baltimore, Maryland 21286 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) as a consequence of): **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit and resulting in death) Last Due to (or as a consequence of) of Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de: 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 2 Fetal death 3 Ectopic pregnancy Day Month Year 4☐ Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown

the funeral director. Medical Certification: To Be After after death.

Brown

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably

24a. Was an autopsy performed? 1 ☐ Yes 2 X No 26. Place of Death (Check only one)

24b. Were autopsy lindings available prior to completion of cause of death?
1 ☐ Yes 2 Å No

25. Was case referred to medical examiner? 25 1 🗌 Yes 27. Manner of De 1 Natural
Accident

3 Suicide

29a. Certifié

4 Thomicide

5 Pending investigation 6 ☐ Could not be

1 Inpatient 2 X FR/Outpatient 28a. Date of Injury (Month, Day Year)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

3 DOA 28b. Time of м

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred 28l. Location (Street and Number or Rural Route Number, City or Town, State)

Centrying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

The dical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signa ure and title of certifier

Sain + Paul St, Sute 5, Bulto, MD 21218

Registrar

completaly filled in by

31. Date liled (Mor State

rick 32. Registrar's Signature

ed cause of death (Item 23a) (Type, Print)

or Attending Physician:

To the Hospital within 24 hours a

Division

06-08224 Delores Byrd

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

(), (), ()		- For State	Certificate of Dea	nth	Reg	<sub>3. No.</sub> 2005	3494
Physician	1/	Decedent's Name (First, Middle, Last)	BYRD		Date of Death     Month	Day Year	ime of Death 107 hrs
Medical Examine		DELORIS  4a. Facility Name (if not institution, give street and number)		. Town, or Location of Death	October 31	4c. County of Death	107 1113
		Sinai Hospital	Balt	imore		NA	
Funeral	,	4	(In yrs last birthday) If Ur	ider 1 Year   If Under 24Hrs ths   Days   Hours   Min	-	Foreign	ce (State or
Director	2	2/8-26-5297 1 M 2XF	Yrs.		MAY 23	8,1932 Country	MARYZAND
апу		Jsual Residence of Decedent  10a. State 10b. County	10c City, Town or Location		/		. Inside City Limits
ž .	5/	MARYLAND N/A	Bi	ALTIHORE	CITY	/	Yes 2 No
ith the Maryland 23a or 28a-f show notified at once.	20	Oe. Street and Number	10f. Z	ip Code	1/2	g. Citizen of What Country?	
hours after death with the Maryland "natural", or items 23a or 28a-f sho Examiner must be notified at once	Funeral Director	3902 WINDSOR MI	LL ROAD	dent of Hispanic Origin? (S	7 pecify Yes or No-	USA.	ndian. Black.
leath w items	al l	1 Never Married 2 Married Armed Forces?		cify Cuban, Mexican, Puerto		White, etc.	
after d	<u>s</u> -	3 Widowed 4 Divorced If Yes, Give Year or Dates:	1 Yes	2 X No specify:		Specify BLA	
5-0036 led within 72 hours after Hygiene other than "natural", the Medical Examiner	를 -	15. Decedent's Education (Specify only highest grade completementary/Secondary (0-12)  College (1-4 or 5	during most of w	al Occupation (Give kind of orking life. DO NOT use ret		16b. Kind of Business/Indus	try
thin 72 te than "	Completed	2 VRS	CUSTOME	R SERVICE	REP.	VITALR	ECORAS
215-0036 be filed within ntal Hygiene rked other tha ent, the Medic		17 Father's Name (First, Middle, Last)	2	18. Mother's Name	(First, Middle, M	aiden Surname)	
e a e c	g P	LEROV  19a. Informant's Name elationship (Type, Print)	DO VER	DORO ss (Street and Number or		DONES per, City or Town, State, Zip	Code)
nore, MD 2 gges I and 2 shou nt of Health and N t: If item 27 is n other traumatic	2	AUGUSTUS BURD (HUSB		WINDSOR MILL		LTIHORE MD.	21216
re, rand land Healt fitem	- 1	20a Method of Disposition  1 X Burial 2 Cremation 3 Removal from Sta	20b. Place of Disposition (N	ce)	Date/	20c. Location - City or Town	·
Pages Pent of		4 Donation 5 Other Specify:	WOODLAWN (	EMETERY 11-	07-2006	WOODLAWN,	MARYLAND
Baltimore permit Pages I a Department of He Important: If it injury or other t		21. Signature of Funeral Service Licensee	22. Name ar		OWN JA	R. FUNERAL BALTIMORE. MD	HOME
Physician		23a Part I Enter the disease, or complications that caused to	the death. Do not enter the mod	e of dying, such as cardiac		st, shock, or heart Ap	proximate Interval
/Medical Examiner		failure. List only one cause on each line.  Immediate Cause (Final disease a Multiple Injuries				В	etween Onset and Death
Exammer	1	or condition resulting in death)  Due to (or as a conse	quence of):				
10	اةِ	Sequentially list conditions, if any, leading to immediate Due to (or as a conse	quence of):				
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cuted nd transit		dd					
760, reate be executed physician and the burial - transit	Medical	UNPENDED					
8760 ifficate b		IF FEMALE: 23c. If yes, outcom 25c. Was decedent pregnant in the	ne of pregnancy  Petal deal	h 3 Ectopic pregna	ancy	23d. Date of delivery  Month Day	Year
Box 687 death certifi the attending of for use as t	Sicia	1 Ven 2 d No 0 Ulakanua	time of death 5 Other (Sp				
hed the	Physician	Part II. Other significant conditions contributing to death	but not resulting in the underly	ng cause given in Part I.	23e. Did tob	pacco use contribute to the c	ause of death?
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Reco The law cate has	Completed				perform 1 <b>V</b> Yes 2	ned? death?	2 No
Vital Recysician: The his certificate director, page	آ Be	25 Was case referred to medical examiner?		26 Place of Death (Check	<del></del>		
Division of Vital Records, P.O. tal or Attending Physician: The law requires that it is after death all Director: After this certificate has been signed by led in by the funeral director, page 2 should be detack.	위	1 Yes 2 No Inpatien  27. Manner of Death 28a. Date of Injur	nt 2 ER/Outpatient 3  28b. Time of Injury	DOA Nursii 28c. Injury at Work?		Residence 6 Other:	
ion of Vending Pheath	<u>ë</u>	1 Natural 5 Pending Oct 31, 2006		1 Yes 2 ✔ No	Driver auto a		
Visic or Atte fiter dez Directo in by th	lica	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Inj	jury - At home, farm, street, facto	ory, office building, etc.	28f. Location (St or Town, St	treet and Number or Rural R	oute Number, City
Division septial or Attent hours after death uneral Director: y filled in by the	Certification:	4 Homicide determined (Specify) Maj	jor Road / Highway		5200 Blk. Wab	ash Ave, Baltimore, MD	
Division To the Hospital or Attent within 24 hours after death To the Finteral Director: completely filled in by the		29a Certifier (Check only one)  Certifying Physician: To the best of my one)  Medical Examiner: On the basis of exam					use(s)
To the within To the comple	Medical	and manner stated  29b Signature and title of certifier		29c License number		29d Date signed (Month, E	
		Sunate Or mithall MA		O.C.M.E.		November 1, 2006	
	T	30. Name and russ of person who completed cause of di			4D 0:00		
2		Pamela E. Southall, MD Assistant Media  31. Date filed (MoNth Pay, Year) 2000 32. Registrar	Size at the size of the size o	nn Street, Baltimore, I	VID 21201		
Sta Registr		31. Date filed (MoNth) Pay, Year 3 2006 32. Registrar		J.			

			For State Ragistrar	State of Maryla		epartmen <i>Certificaț</i>			Mental Hy	giene Reg. No.	006	34950
	Physici	an	1. Decedent's Name (First, Middle, Last Earl Frede:		n				2. Date of De Month	Day	Year	3. Time of Death
	/Medic Examin	al	4a. Facility Name (If not institution, give			4b. City,	Town, or	Location of Death	1	4c. C	ounty of Death	11,
					Spita yrs. last birtho		RO	SECAL OF Under 24 Hrs.	8 Date of Bi	16	Saltir 9 Births	MORE place (State or Foreign
	Funeral Director			_	85 Yrs	Months	Days	Hours Min.	8. Date of Bi Aug 12	, 1 <sup>4</sup> 9°21	West	place (State or Foreign ntry) Virginia
	land ow		Usual Residence of Decedent  10a. State 10b. County	10c.	. City, Town o	r Location					1	10d. Inside City Limits
	the Maryland r 286-1 ehow	ctor	MD Baltim	ore	Ess	ex						1 Yes 2 No
	death with the Maryland ms 23a or 28e-1 ehow	Funeral Director	10e. Street and Number 401 Margaret	Ave.		10f. Zip	212	221		10g. Citize	en of What Cour	ntry?
036		۵	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces?  ↑ Yes 2 □ No If Yes, Give Year or Dates:	in U.S.	13. Was Dece If Yes, spe 1 \(\sum \) Yes		ispanic Origin? (Si an, Mexican, Puert Specify:	pecify Yes or No o Rican, etc.)		4. Race - Americ Black, White, Specify: Whi	etc.
FOR 1215-0036	within 72 hours after ene. than "naturel", or Ite	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)	college (1-4or 5+)	(C	ecedent's Usu Give kind of wo fe. DO NOT u	se retired	during most of wor i)	king		d of Business/In	dustry
and 21	s 1 and 2 should be filed within Health and Mental Hygiene, Item 27 is marked other than " other treumatic event, the Ma	Be	17. Father's Name (First, Middle, Last) Earl R. Brown					18. Mother's Nan Grace	ne (First, Middle e Gil	lespi	iumame) Le	
S lary	2 shouk and Me is mark	7	19a. Informant's Name/Relationship (7		19b. N	Mailing Address	(Street	and Number or Ru	ral Route Numb	er, City or	Town, State, Zip	Code)
Baltimore, Maryland			Donald Brown  20a. Method of Disposition  Burial 2 Cremation 3	20	b. Place of D	isposition (Na	me of	metery	Date	20c. Loca	ation - City or To	own, State
atim Co	permit. Pages 1 en Department of Heali Important: If Item 2 eny Injury or other		4 Donation 5 Other (Specify  21. Signature of Funeral Service Licen	,	нотту	22. Name at					e. Bal	
ä	Per Ing		→ Chustud	rolles		Conn	elly	7 Funer	al Hom	e of		
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	/Medical Examiner		resulting in death)	Due to (or as a con	nsequence of)	Rgan : DSIS						
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ds, P.	uires that the signed by		Part II. Other significent conditions of	entributing to death but not	t resulting in th	he underlying	cause giv	en in Part I.		tobacco us		the cause of death?
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u	Hospita 14 hours Funeral tely lilled	Medical Ce	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exap	ysician: To the best of my niner: On the basis of example and manner stated.	knowledge, omination and/	death occurred or investigation	at the tin	me, date and place opinion, death occu	e, and due to the urred at the time	cause(s) a , date and p	and manner as solace, and due t	stated. o the cause(s)
	To the within 2 To the comple	Med	29b. Signature and title of certifier	my)		29		se number / 8 7 / 7		29d. Date	signed (Month,	Day, Year)
	10		30. Name and address of person who	completed cause of death	(Item 23a) (T	ype, Print)				11/	11100	
	\			Seling ER 32. Hegistrar's S	9000	FROM	nKli	N Sq d	IR. Ba	altimo	ORE, M	D 21237
	Sta Regist	ate rar	NOV 0 3 20	106 America	J.	Goods	,					

		1 - For State Registrar	State o	of Ma	ıryland		artmen rtificat		ealth and N Death		Reg. No2	06	34951
Dhuai		1. Decedent's Name (First, Middle,	Last)							2. Date of De Month	Day	Year	3. Time of Death
Physic /Med		Ida			Basi	ile				October	31, 2	006	11:15 PM
Exam		a. Facility Name (If not institution,	give street and nu	ımber)			4b. City,	Town, or	Location of Death	1	4c. Cour	nty of Death	
		Suburban Hospit	a1					nesda		· · ·		gomer	·
Funera	I		6.Sex 1 ☐ M: 2 🕅 F		(In yrs. la:	st birthday) Yrs.	If Under Months	1 Year Days	If Under 24 Hrs. Hours Min.	B. Date of Bir (Month, Da April 8	th ly, Year)	9. Birth	place (State or Foreig
Directo		051-09-2931	241	9	U	115.				April 8	, 1916	New	York
b and		Usual Residence of Decedent  10a. State 10b. County			10c. City,	Town or Lo	cation						10d. Inside City Limits
anyli	5				Tiest		-						1 ∑Yes 2 ☐ No
he N	ect	D.C. None			wasi	ningto	10f. Zip	Code			10g. Citizen o	of What Cou	intry?
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C Z IZ I 3-UU30 filed within 72 hours after deeth with the Maryland Hygiene. other then "natural", or Iteme 23e or 28e-f show ent, Itemesical Esa afractional be notified at	by Funeral Director	3543 Chesapeake		N.W		13			ispanic Origin? (Sr	pecify Yes or No		ace - Ameri	ican Indian.
oemit. Peges 1 and 2 should be filed within 72 hours after de Department of Health and Mental Hygiene. Important: If Item 27 le marked other then "natural", or Item ny Injury or other treumatic event, Ite Medical Exaction	Į,	11. Marital Status 1 ☐ Never Married 2 ☐ Marrie	12. Was Dec Armed F ad 1 ☐ Yes	orces?	10.5	. 13.	If Yes, spec	rfy Cuba	ispanic Origin? (Sp in, Mexican, Puero	Rican, etc.)	8	lack, White	
rs aft	2	3 ☑ Widowed 4 ☐ Divorced	If Yes, G	ive			1 🗌 Yes	2🛛 No	Specify:		Spe	city: Wh:	ite
5 4	8	15. Decedent'				16a. Dece	dent's Usua	al Occup	ation		16b. Kind of	Business/Ir	ndustry
2 3	Completed	(Specify only highest	grade completed			(Give life.	kind of wo DO NOT u	rk done d se retired	ation during most of word f)	king			
rthen	l E	Elementary/Secondary (0-12)	College	(1-40r 5	+)	1	lanage	er			F	ood	
	O	17. Father's Name (First, Middle, L	ast)						18. Mother's Nan	ne (First, Middle	, Maiden Sum	ame)	
le marked o	To Be	(Unknown)							Ida Rio	caboni			
Tage of the same o		19a, Informant's Name/Relationsh	ip (Type, Print)			19b. Maili	ng Address	(Street	and Number or Ru	rai Route Numb	er, City or Tov	vn, State, Zi	p Code)
treu		Edward Basile (							ke St. NV		ington,		
Item 27 le marked othe other treumatic event,		20a. Method of Disposition			20b. Pla	ice of Dispo	sition /Nan	ne of	1	Date	20c. Locatio	n - City or T	own, State
		14 Burial 2 Cremation 4 Donation 5 Other (Sp		State	1				<sup>20)</sup>   11-3 1 Cemete		Calve	rton,	NY
Department of Important: If eny Injury or		21. Signature of Funeral Service L		)	July								
eny e		1 / / /	12/	11	1000	_   1	New Hy	yde :	ss of Facility Park Fund ille Rd.	eral Hon	ne ide Par	k. NY	11040
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		shock, or heart failure. List of immediate Cause (Final	only one cause on	each lin	10.								Onset and Death
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ending physic	Physician/Medical		1					fr	<u> </u>				
endin use	N S	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, o	utcome	of pregnan	cy death 3.f	]Ectopic p	regnancy	,			Date of deliv	•
e atte	Icla	in the past 12 months? 1 ☐ Yes 2 XNo		nant at	time of dea		Other (sp			-		Month	Day Year
by the	hys	9 Unknown											
igned be del	by P	Part II. Other significant condition		death bi	ut not resul	ting in the u	inderlying o	ause giv	en in Part I.				the cause of death?
within 24 hours after death. To the Funerel Director: After this certificete has been signed by the attending phys completely filled in by the funeral director, page 2 should be deteched for use as the		Atrial Fibrilla	ition							10	Yes 2□No	3 Pro	bably 4 Dunknow
2 5	Completed	Dementia								24a. Was	s an 24	b. Were aut	opsy findings available ompletion of cause of
ete ha	E O									perfe 1 ☐ Yes	ormed?	death? 1 ☐ Yes	
rtifice stor, I	Be	25. Was case referred to medical							26. Place of Dea	ath (Check only	one)		
direct	10	examiner? 1∰Yes 2☐No	Hospital: 1	Inpatie	ent 2 🗆 E	R/Outpatie	nt 3 🗆 D	Oth Oth	er: 4 Nursing H	lome 5□Res	idence 6 🗆	Other (Spec	ufy)
After this certificete ha		27. Manner of Death 1 ⊠Natural 5 ☐ Pending	28a. Date (Mo	e of Inju	ry y Year)	28b. Time o	of 2	28c. Injur Wor	y at k?	28d. Describe	how injury occ	curred	
arn.	atle	2 Accident investig	ation				М	1 🗆	Yes 2 □No				
recto	t t	3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determ	ned   288. Flat		ury - At hor	ne, farm, st	reet, factor	y, office		28f. Location City or To	(Street and Nu own, State)	mber or Ru	ral Route Number,
ed in	Certification:												
To the Funeral Director: completely filled in by the	edical	29a. Certifier 1 💢 Certifyin	g Physicien: To the Examiner: On the										
within 24 hours after death  To the Funerel Director: /	Pe			nen sta									
- CO	Σ	29b. Signature and title of certifier	0 +	/_/	<b>a</b>		29	c. Licens	e number		29d. Date sig		
,		alydo	1 V		<u> </u>			WD	4369	/	Novemb	er 1,	2006
V	7	30. Name and address of person							-	D . 1	3/70	0001/	
		Alexandros I					l Geo	get	own Rd.,	Bethesd	a, MD	20814	
	tate	31. Date filed (Month, Day, Year)	32.	Registr	ar's Signati	ure	- 4						
Regi	strar	MAYA	3 2006	4.	.412 A	pa .	Local	2					
IH 17 Rev	1/2001	115 x A	S FAAA	Service Control	Carrier de	1	I A I A						
						ORIG	INAL						

**Funeral** Director vith the Maryland r 28a-f show notified at e o

	13 Th	a	229 Palomino Plac	ce		254	14			US
	ms me	Punera	11. Marital Status	12. Was Decedent Ever in U.: Armed Forces?	S.	13. Was Deced	ent of Hispanic C ify Cuban, Mexic	Origin? (Specify	Yes or N	10-
	ter ite	Ē	1 ☐ Never Married 2 ☐ Married	1 ☐ Yes 2 No		·			111, 610.)	
36	ours after death	by	3 ☑ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2	No Specif	y:		
Baltimore, Maryland 21215-0036	filed within 72 hours after death Hygiene. vither than "natural", or items 23 ant, the Medical Examiner must	Completed	15. Decedent's Ed (Specify only highest grad	ucation de completed)	//	ecedent's Usua Give kind of wor ife. DO NOT us	k done durina m	ost of working		16b.
2	ithin han e Me	ш	Elementary/Secondary (0-12)	College (1-4or 5+)						Не
7	ed w ygie er t t, th	S	12		Nu	rse Ass		h - d- N1 /E'		
pu	be fill ntal H id oth even	Be	17. Father's Name (First, Middle, Last)				18. MOI	ther's Name (Fi	rst, Middi	е, маю
<u>ھ</u>	Aent Aent rked tic e	2	Charles Longerbe	am			F	rances	Jenk	ins
E S	should be filed wi and Mental Hygien is marked other th aumatic event, the		19a. Informant's Name/Relationship (7	ype. Print)	19b. N	Mailing Address	Street and Num	nber or Rural Ro	oute Num	ber, Cit
ž	and 2 ealth a n 27 is		Sherry Painter/D	aughter	156	Warrio	r Drive	, Bunke	r Hi	11,
é,	1 and Health tem 27 other tr		20a. Method of Disposition	20h P	lace of D	isposition (Nam	e of	Date		20c.
mor	permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any Injury or other traumatic event, the Medical once.		1 ☐ Burial 2 ☑ Cremation 3 ☐ 4 ☐ Dopation 5 ☐ Other (Specify	Removal from State Me	trop emat	crematory or of colitan cory	nerplace)	10-28-	ი6	<b>A</b> .
ati	permit. Departr Importa any Inju		21. Signature of Funeral Service Licens	see		22. Name and	Address of Fac	ility Hall	Fun	era.
ä	De la la la la la la la la la la la la la		L'ennis (	allman	.	PO E	ox 896,	Purcel	lvil	1e,
			23a. Part1. Enter the disease, or comp	lications that caused the death	. Do no	t enter the mode	of dying, such	as cardiac or re	spiratory	arrest,
п			shock, or heart failure. List only of Immediate Cause (Final	one cause on each line.						
â	Physician		disease or condition resulting in death)	a						
	/Medical		Toolang ar county	Due to (or as a consequ				0	-0 "	· ' - '
4	Examiner		Sequentially list conditions,	b. Septice	Mp	0105	from e	MAJOCE	WAL	ns
3		ner	if any, leading to immediate cause. Enter Underlying	Due to√or as a consequ	ience of)	:				
>	uted d ansit	Ē	Cause (Disease or injury that initiated events	C						
<u>_</u>	or Attending Physician: The law requires that the death certificate be executed flor death.  Director: After this certificate has been signed by the attending physician and in by the funeral director, page 2 should be detached for use as the burial-transit	Examiner	resulting in death) Last	Due to (or as a consequ	ence of)	:				
9	be e			7						
87	cate phys the	dic		d						
Box 68760	eath certificate be exattending physician for use as the buria	Me	IF FEMALE:	OGs. If use outcome of progres	201					
30	tend tend or us	an/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome pf pregna 1 ☐ Live birth 2 ☐ Feta	death	3 □Ectopic pro				
H	dea e at ed fo	sici	1 ☐ Yes 2 XNo	4☐Pregnant at time of de 9☐Unknown	eath	5 Other (spe	ecify)			
P.O.	uires that the de signed by the a ld be detached f	Physician/Medical	9 ☐ Unknown	JE OTHER DATE						
	tha ned det	by P	Part II. Other significant conditions of	ontributing to death but not resu	ulting in t	ne underlying ca	use given in Par	t I.	23e. Dio	1 tobacc
ds	uires I sign	d D	Sepsis						1 [	Yes
Ö	w requ	Completed						-	24a. Wa	e an
ě	law las	du							aut	topsy
<u>—</u>	The ate bage	ő							1∐ Yes	rformed
ita	an: rtific tor,	Be (	25. Was case referred to medical				26. Pla	ace of Death (C	heck only	one)
Division or Vital Records,	Physician: The lavithis certificate has all director, page 2	To B	examiner? 1 ☐ Yes 2 No	Hospital: 1 Inpatient 2 □	ER/Outp	atient 3 DO	A Other: 4	Nursing Home	5 □ Re	sidence
0	Physical controls	<u>:</u>	27. Manner of Death	28a. Date of Injury	28b. Tir	ne of 2	Bc. Injury at Work?		Describe	
n	ding Afte fune	io	Natural 5 Pending investigation	(Month, Day Year)	lnju	ary M	work? 1 ☐ Yes 2	□No		
. <u>S</u>	Attendest death ctor: y the	cal	3 Suicide 6 Could not be	1	me farm	street factory			Location	(Street
.≥	after of Direct of in by	Ę	4 ☐ Homicide determined	28e. Place of injury - At ho building, etc. (Specify	()	i, stroot, radioty	, 011100	201.	City or T	own, St
	ital (rs af	Se								
	To the Hospital or Attending Physician: The law requir within 24 hours after death.  To the Funeral Director: After this certificate has been s completely filled in by the funeral director, page 2 should	Medical Certification:	29a. Certifier 1 Certifying Phy (Check only 2 Medical Exam	ysician: To the best of my kno niner: On the basis of examina	wledge, o	death occurred or investigation	at the time, date	and place, and death occurred:	due to that the time	e cause
	n 24 n 24 ne Fi	di	one)	and manner stated.			,			,
	Nithir To th	ž	29b. Signature and title of certifier			290	License numbe	r		29d.
	> :- 0			11.		10.	11.7/17	C 61-15	A	Do i

1 - For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death OCT OBER **Physician** MAE BROWN 26 2000 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** BALTIMORE BALTIMORE UNIVOF MARYLAND MEDICAL COR If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 ☐ M 2 🗷 F VA 226-84-3476 61 Oct. 12,1945 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State Director 1 Yes 2 No Jefferson Charles Town WV 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 25/1/ USA 14. Race - American Indian, Black, White, etc. Specify: White Kind of Business/Industry ealth Care len Surname) y or Town, State, Zip Code) WV 25413-3103 Location - City or Town, State lexandria, VA 1 Home Virginia 20134 Approximate Interval Between Onset and Death 23d. Date of delivery Month Year Day o use contribute to the cause of death? 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Νo 6 ☐Other (Specify) jury occurred and Number or Rural Route Number, ate) e(s) and manner as stated and place, and due to the cause(s) Date signed (Month, Day, Year) 26,2006 1<del>11</del>141 +6435Q17454 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

0

State

Registrar

SANDRA

31. Date filed (Month, Day, Year)

NOV 03

QUEZADA

32. Registrar's Signature

22 South Greene St., Baltimore, MD

M-P-

06-08100	
Ronald Burke	

Please Type or Print in Black Indelible Ink

	ırke		State of Mary I- For State Registrar		tificate of				Reg No. 2	006 3495
Pl Nedical	hysici: Exami	÷11/	1. Decedent's Name (First, Middle,Last)  Ronald B. Burke					2. Date of De Month October	eath Day Yea 28, 2006	3. Time of Death 2131 hrs
			4a. Facility Name (if not institution, give street and Frederick Memorial Hospital	number)	4	tb. City, Town, or Frederick	Location o		4c. County	
Fu	ıneral		Social Security Number 6. Sex	7. Age (In yrs. Ia	st birthday)	If Under 1 Yea	ar If Under			9 Birthplace (State or Foreign
	ector		148-58-9956 1X M 2 F		48 Yrs.	Months Day	/s Hours	Min. July	28, 1958	Country) PA
	any	-	Usual Residence of Decedent  10a. State 10b. County	10c. City,	Town or Locati	on		·		10d. Inside City Limits
land	\$	ğ	Maryland Frederick	Wal	lkersvi				10. 01	1 X Yes 2 No
he Mary	23a or 28a-f sho notified at once.	ě١	10e. Street and Number 8825 Eureka Lane			10f. Zip Code 21793			10g Citizen of WI	nat Country?
h with t	be not	L	11. Marital Status 12. Was D	ecedent Ever in U.S		s Decedent of His		in? (Specify Yes or Note: )		e - American Indian, Black, e, etc.
ter deat	", or ite er must		1 Never Married 2 X Married 1 X Yes 3 Widowed 4 Divorced If Yes, Give Yor Dates:	2 No	4 1	Yes 2X No	specify:		Specify:	White
hours af	natural	ed by	15. Decedent's Education (Specify only highest g	rade completed)	16a. Deceden	t's Usual Occupa ost of working life		kind of work done use retired)	16b. Kind of Bu	usiness/Industry
36 thin 72	than "q edical F	ompleted		(1-4 or 5+) 2	Phleb	otomist			Medical	Technician
D 21215-0036 should be filed within 72 hours after death with the Maryland	Mental Hygiene marked other than "natural", c event, the Medical Examiner	e Cor	17. Father's Name (First, Middle, Last)  John Burke					s Name (First, Middle th Wing	, Maiden Surname	*)
212. ould be	Department of Health and Mental Hy Important: If item 27 is marked o injury or other tranmatic event, th	മ	19a. Informant's Name/Relationship (Type, Print )				et and Num	ber or Rural Route N		
, MD	ealth an em 27 i tranmat		Donna A. Burke (Wife) 20a Method of Disposition			Eureka I		Walkersvil		1/93 - City or Town, State
Baltimore, permit. Pages 1 ar	ent of H nt: If it other		1 X Burial 2 Cremation 3 Remova 4 Donation 5 Other Specify	I from State OC Me	rematory or oth ean Cou morial	ner place) inty Park		11/3/06	Toms R	liver, NJ
3altir ermit. 1	Departmonders		21. Signature of Funeral Service Licensee	•	22. N M o	lame and Addres	s of Facility	eral Home		
	sician		23a Part I Enter the disease, or complications that failure. List only one cause on each fine.	t caused the death	Do not enter the	O Route	9 Ba	avville. N	IJ 08721 irrest, shock, or he	art Approximate Interval Between Onset and
/Mc	edical miner	1 1	Immediate Cause (Final disease a ather	rosclerotic	cardiova	scular di	sease	минасть		Death
			or condition resulting in death)  Due to (or a Sequentially list conditions, b.	s a consequence of	r): 					
		niner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated	s a consequence of	f):					
ted	ansit	Examine	events resulting in death) Last Due to (or a	s a consequence of	f):				- <del> </del>	
, oe execu	ician and	dical	WORK dead at respect to the	D #23a,27,28	Ba-f.perN	Æ.G861.11	/16/06	TT		
<b>8760</b> tificate b	e attending physician and for use as the burial - transit	ın/Me	IF FEMALE. 23b. Was decedent pregnant in the past 12 months? 23c. If ye 1 Liv	s, outcome of pregr e birth	nancy	tal death 3		pregnancy	23d Date of Month	f delivery Day Year
ox 6	attendi for use	/sician/	4 Pre	egnant at time of dea known	ath 5 Ot	her (Specify)				
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed	ned by the detached	y Physi	Part II. Other significant conditions contributing		esulting in the u	underlying cause	given in Pa			ribute to the cause of death?
Is, P.	s been signed be should be deta	ted by			<u>,,</u>	-		1Y 24a. Wa		Probably 4  Unknown  Were autopsy findings available
SCOFC e law re	e has be	Completed							formed?	prior to completion of cause of death?  Yes 2 No
al Re inn:⊞	s certificate rector, page	Be Co	25. Was case referred to medical examiner?			26 Plac	_	(Check only one)		<b>2</b> 100
of Vit	After this of funeral dire	70	1 ✓ Yes 2 No 28a. Da 28a. Da	ate of Injury	ER/Outpatient 28b Time of I		Other	Nursing Home 5 28d Describ	Residence 6	Other:
ion C	eath. tor: Af the fun	ation	1 Natural	onth, Day, Year) 10/28/2006	Fnd 8:35	5 pm 1	Yes 2 X	No unknow	n	
Divis	s after d	Certification:	3 Suicide 6 X Could not be determined	lace of Injury - At ho		et, factory, office	building, et	c. 28f Location or Town	(Street and Numb State) 8825 I sville, MD	per or Rural Route Number, City Eureka Lane
II split	24 hours Funeral etely fille		29a Certifier 1 Certifying Physician: To the	best of my knowledg	ge, death occur	rred at the time, o	date and pla	ace, and due to the ca	use(s) and manne	r as started
To the	vithin To the complet	Medical	one) 2 Medical Examiner: On the base and manner  29b. Signature and title of certifier	sis of examination a er stated	nd/or investiga		on, death oc	curred at the time, da		due to the cause(s)  ned (Month, Day, Year)
		-	Thereon Il Vind .	Α Δ			.M.E.		October 29	
16	2)		30. Name and address of person who completed of	ause of death (Item stant Medical E		111 Ponn S	treet Ro	Itimore, MD 212	01	
-	<u>\$</u>	tate	Theodore M. King, Jr., MD. Assis	starit Medical E		and and	cci, Da	manore, WD 212		· · · · · · · · · · · · · · · · · · ·

### 06-08043 UNK UNK

Leonard Brown

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar	Certificate of L	Death	Reg. N	10. 200	5 3495
Physici cal Exami		Decedent's Name (First, Middle,Last)     Leonard	Brown		2. Date of Death Month Da October 26, 2	y Year	3. Time of Death 0154 hrs
		4a. Facility Name (if not institution, give street and number) Johns Hopkins Hospital		City, Town, or Location of Dea Baltimore		4c. County of Death	1
Funeral Director		400-19-4168 1XM 2F		If Under 1 Year If Under 24H Months Days Hours M	1 8. Date of Birth (Min. 9–15–19	9. 8 ir 981 Foreig Co	
w any		Usual Residence of Decedent  10a State 10b. County	10c. City, Town or Location				10d Inside City Limits
should be filed within 72 hours after death with the Maryland and Mental Hygiene 7 is marked other than "natural", or items 23a or 28a-f show natic event, the Medical Examiner must be notified at once.	Director	Md. NA  10e. Street and Number	Baltimor 1	Ce 10f. Zip Code	10g. (	Citizen of What Cou	1 Yes 2 No
ith the Maryland  23a or 28a-f show notified at once.		1433 Winston Avenue  11. Marital Status 12. Was Decedent	Free in LLC 42 Who I	21239 Decedent of Hispanic Origin? (	Charify Vac or No	USA	ican Indian, Black,
death wi or items must be	Funeral	1 X Never Married 2 Married Armed Forces 1 Yes 2	If Yes	, specify Cuban, Mexican, Pue		White, etc.	
natural",	by	Widowed 4 Divorced If Yes, Give Year or Dates.  15. Decedent's Education (Specify only highest grade continuous)  15. Decedent's Education (Specify only highest grade continuous)	npleted) 16a. Decedent's	es 2 X No specify:  Usual Occupation (Give kind of tof working life, DO NOT use for the second secon		Specify Bla	
or not med white the moust are fental Hygiene arrked other than "natural", event, the Medical Examiner	Completed	Elementary/Secondary (0-12) College (1-4 or 11th grade	5+) Prep-0	Cook	I	Express Pe	ersonal Ser
Mental Hygi marked oth c event, the	Be Co	17. Father's Name (First, Middle, Last)  Leonard	Ivory	18 Mother's Nat Laqu	me (First, Middle, Maid ana	- 1	Brown
lealth and Mental tem 27 is marked traumatic event,	To	19a. Informant's Name/Relationship (Type, Print)  Sharita Brown Sister		ddress (Street and Number of Winston Avenue			e, Zip Code) 21239
Department of Health Important: If item 2 injury or other traun		20a Method of Disposition  1 X Burial 2 Cremation 3 Removal from St	20b. Place of Disposition	on (Name of cemetery, r place)	Date 20	c. Location - City or	Town, State
Departme Importat injury or		21. Signature of Funeral Service Licensee		ne and Address of Facility  Ol E. North Av	March F.I e., Baltim		21202
sician edical		23a. Part I. Enter the disease, or complications that caused failure. List only one cause on each line.	the death. Do not enter the				Approximate Interval 8 etween Onset and
aminer		Immediate Cause (Final disease or condition resulting in death)  a. Gunshot Wound Due to (or as a const	ds (2) To The Head equence of):				Death
	ıer	Sequentially list conditions, if any, leading to immediate b. Due to (or as a cons	equence of):				
and - transit	Examiner	cause Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last d	equence of):				
sician and	Medical	UNPENDED					
within 24 hours after death  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	sician/	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown  23c. If yes, outcomed to be past 12 months?  24c. If yes, outcomed to be past 12 months?  1 Unknown  25c. If yes, outcomed to be past 12 months?	2 Fetal	death 3 Ectopic pres	1	23d. Date of deliver	y Day Year
ed by the	by Phy	Part II. Other significant conditions contributing to deat	h but not resulting in the unc	derlying cause given in Part I.			the cause of death?
been signed I					24a Was an	24b. Were au	utopsy findings available
certificate has be ector, page 2 sh	Completed				autopsy performed		es 2 No
nis certif director,	o Be	25. Was case referred to medical examiner?  1 ✓ Yes 2 No Hospital: 1 Inpatio	ent 2 🗹 ER/Outpatient 3	26.Place of Death (Chera Donald Donal		idence 6 Othe	r:
ath or: After this the funeral dir	-	27. Manner of Death  1 Natural 5 Pending  28a. Date of Injuny (Month Day) Oct 26, 2006	year) 28b. Time of Inju	28c. Injury at Work? 1 Yes 2 ✓ No	28d. Describe how Subject was sh		
ours after de eral Directo Tilled in by t	Certification	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify) Lo	njury - At home, farm, street, cal Street	factory, office building, etc.	or Town, State		iral Route Number, City e, MD
within 24 ho To the Func	Medical C	29a. Certifier (Check only one) 2 Medical Examiner: On the best of m and manner stated.	mination and/or investigation				
: ¥ £ 8	Me	29b. Signature and title of certifier		29c. License number O.C.M.E.		d Date signed (Mo	
1		30. Name and address of person who completed cause of a Pamela E. Southall, MD Assistant Med		Penn Street, Baltimore	. MD 21201		
s	tate	0.00	ar's Signature	The second	,		

		•	1 - For State Registrar	State of M	larylan	id / Depa	artmer rtificat	t of Hea e of De	Ith and I ath	Mental Hy	giene Reg. No.	006	3495	55
	Physic	an	Decedent's Name (First, Middle, La	st)		0		2		2. Date of De Month	Day	Year	3. Time of Dea	
	/Medi		Earnestine			Synthi			rney	10	29	2006	11:08p	- M
	Exami	ner	4a. Facility Name (If not institution, gir 6022 Amberwood	Rd. Apt.	C-2		Ba	Town, or Local  Itimore				NA		
	Funeral Director			Sex 7. A 1 □ M 2√2√F	ge (In yrs. 54	last birthday) Yrs.	Months		ours Min.	8. Date of Bi (Month, Di 9-10-	ay, Year)	9. Birth Cou	place (State or Fo intry) Va.	)reign
	D		Usual Residence of Decedent		7									
	urytan show	Ļ	10a. State 10b. County N	7	10c. Cit	y, Town or Lo	cation cimor	^					10d. Inside City Li 1 Yes 2	
	Ba-f s	ecto		n.		Dari	1				10a Citia	en of What Cou		
	s 1 end 2 should be filed within 72 hours after death with the Maryland if Heelth and Mental Hygiene Item 27 is marked other then "natural", or iteme 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at	Funeral Director	10e. Street and Number 6022 Amberwood	Road Apt	. C2		10f. Zip	21206			rog. Citiz	USA	untry r	
	leath	eral	11. Marital Status	12. Was Deceden	t Ever in U	.S. 13.	Was Dece		nic Origin? (S	pecify Yes or No o Rican, etc.)	)- I	4. Race - Amer		
ထ	or iter	F	1 ☐ Never Married 2 ☐ Married	Armed Forces						o Rican, etc.)		Black, White		
93	iral', c	d by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates			1 🗆 Yes	200 NO 31	ecify:				lack	
21215-0036	natu	Completed	15. Decedent's E (Specify only highest gr	ducation a <i>de completed)</i>		(Give	kind of wo	al Occupation ork done during se retired)	g most of wor	king	16b. Kin	d of Business/Ir	ndustry	
121	withir ene. then	d m	Elementary/Secondary (0-12)  12th grade	College (1-4or	5+)			loyed			Soc	cretaria	2.7	
	filed within Hygiene. other ther sent, the Ment		17. Father's Name (First, Middle, Las	")		Deri			Mother's Nan	ne (First, Middle			<b>4.L</b>	
au	should be and Mental Ind Mental Ind marked o	To Be	Cleveland		Day			Sł	nirley		Palr	ner		
Maryland	2 should be filed withir and Mental Hygiene. Is marked other than surmatic event, the Ma		19a. Informant's Name/Relationship	•			-			ral Route Numb				
	1 end 2 Heelth tem 27 l		George Barney	Husba		A CONTRACTOR OF THE PARTY OF TH			Road,	Apt. C-				2120
ore	Pages 1 nent of H int: If Ite		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 [	Removal from State	.   4	Place of Dispo cometery, cres	natory or o	other place)	11-3	Date		ation - City or T		
Baltimore,			4 ☐ Donation 5 ☐ Other (Special Signature of Funeral Service Lice		18	st. Bar		nd Address of				hville	, Vd.	_
Bal	Departr Departr Imports eny Inju		21. Signature of Funeral Service Lice	11500						March E ., Balt			21202	
	Physician /Medical Examiner	Iner	23a. Part1. Enter the disease, or conshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury)	a. Due to (or a	s a conseq	uence of):	_	de of dying, su	_	or respiratory a			Approximate Interval Betwee Onset and Deat	n th
x 68760,	The law requires that the death certificate be executed as been signed by the attending physicien and page 2 should be detached for use as the burial-transit	Physician/Medical Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c										
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Il Records,	The law requir cete has been s page 2 should	Completed								24a. Was auto perf 1 Yes		24b. Were aut prior to co death? 1 \( \text{Yes}	opsy findings avai ompletion of cause 2 No	ilable e of
Vital	Physicien: Th this certificete ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:				Other		th (Check only				
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O	ding Phy h. After thi funeral o	ton	1. Natural 5 Pending 2 Accident investigate	28a. Date of In (Month, D	ay Year)	Injury	м	28c. Injury at Work? 1 ☐ Yes	2  No		,,			
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	To the within 2 To the complet	Me	29b. Signature and title of certifier				29	c. License nur	nber		29d. Date	signed (Month	Day, Year)	
	1		1000	And.				PYY9	YY		oct	oban:	31,200	6
-1	2		30. Name and address of person who	completed cause of	death (Iter	33a) (Type,	Print)	onth	Crla	J Vice	JB	things	31,200 e Ma	כונו
	St Regist	ate rar	31. Date filed (Month, Day, Year)	2008 32. Regis	trar's Signa	ature !	Good	25						

			1- For State Registrar	State of Mar			t of H	ealth a		lental Hygi	ene	) 6	349	156
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	Physic		Helen	Bandur						November	Day 1. 20	Year 006	5:56	Ам
li e	/Medi Examir		4a. Facility Name (If not institution, give str	eet and number)		4b. City,	Town, or	Location o	f Death	110 1011001	4c. County		3.50	
2			Wilson Health Care	Center			Gai	thers	shure	·	Moi	ntgon	ne rv	
	Funeral		5. Social Security Number 6. Sex	7. Age (/	In yrs. last birthday)	If Under Months		If Under 2 Hours		8. Date of Birth (Month, Day,			place (State ontry)	or Foreign
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	pur *		Usual Residence of Decedent  10a. State 10b. County	11	Oc. City, Town or Lo	cation							10d. Inside C	its Limits
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	the N	ect	10e. Street and Number	- У		Gaitl		burg		10	a Citiana at 1	Ath - A Co		
	with a or	ā		1	-	10f. Zip				10	g. Citizen of \			
	eath	by Funeral Director	150 Chevy Chase St	Was Decedent Eve		Was Deced	208		in? (Sne	acify Ves or No.	Unite		ates	
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21215-0036	within 72 hours after death with the Maryland she. then "neturel", or iteme 23e or 28e-f ehow he Medical Examinar must be notified at	Completed	15. Decedent's Educa (Specify only highest grade of	ion	16a. Deced	dent's Usua kind of wor	l Occupa	ation	-4	11	6b. Kind of B	usiness/lr	dustry	· · · · · · · · · · · · · · · · · · ·
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nd	d oth	Be	17. Father's Name (First, Middle, Last)					18. Mother	r's Name	(First, Middle, Ma	a <i>iden Sum</i> an	10)		
yla	2 should be and Mental is marked o	은	Vasily Fedor						Anna	Korch				
Maryland	ges 1 and 2 should be filed within 72 hours after death with the Marylan It of Health and Mental Hygiene. If item 27 is marked other then "neturet", or iteme 23a or 28a-f ehow or other traumatic event, the Medical Examination at the retified at	1	19a. Informant's Name/Relationship (Type	•						I Route Number,				
	1 and Health em 27 ither tr		Barbara Kawczynski	-						#205, G				land
or.	Pages 1 nent of H int: if ite iry or ot		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Ren	noval from State	20b. Place of Dispo Holy Cros Mauso	natory or of	ne of ther place	9) N	loven	mber o,	0c. Location -	City or To	own, State	
Ë	Par imen jury	1 4	4 □ Donation 5 ဩ Other (Specify) E	ntombment					20	IN.	orth Ar			
Baltimore,	permit. Pages Department of Important: If i eny injury or once.		21. Signatur / Funeral Service Licensee	MO	01473	. Name and	d Addres	s of Facility	Rob Chas	ert A. P e. Inc., 20814	umphre 7557	y Fu Wisc	neral onsin	Home/ Ave.
+3			23a. Part1. Enter the disease, or complica shock, or heart failure. List only one		e death. Do not ent	er the mode	of dying	, such as o	cardiac c	r respiratory arres	st,		Approximat Interval Bet	8
N	Physician		Immediate Cause (Final disease or condition	Faile	10141	Dre	ne	1a	de	elt		6	Onset and	Death ,
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Вох	attend attend for us	lan	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2	Fetal death 3	Ectopic pre					23d. Dai Mo	te of delive nth		Year
o.	the de	yslc	1 ☐ Yes 2 🖾 No 9 ☐ Unknown	4☐Pregnant at tim 9☐ Unknown	e or death 5	Other (spe	эспу)							
٥.	res that the de igned by the a be detached f		Part II, Other significant conditions contri	outing to death but n	ot resulting in the ur	nderlying ca	use dive	n in Part I.		23e. Did toba	icco use conti	ribute to t	ne cause of d	eath?
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Division	or Attendi after death. Director: A in by the fu	flca	3 Suicide 6 Could not be	28e. Place of Injury	- At home, farm, stre	eet, factory.				28f. Location (Stre	et and Numb	er or Rura	i Route Num	ber
á	after Dire	Certification:	4 Homicide	building, etc. (	Specify)	.,,				City or Town,				
	e Hospital or Al n 24 hours after of the Funeral Directer of the filled in by		29a. Certifier 1 Cartifying Physic	an: To the best of m	ry knowledge, death	occurred a	at the time	e, date and	place, a	and due to the cau	se(s) and ma	nner as s	tated	
	To the Hospital or Attending Physician: within 24 hours after death or the Funeral Director After this certifical completely filled in by the funeral director,	edical	(Check only 2   Medical Examiner one)	On the basis of ex and manner stated	amination and/or inv	estigation,	in my op	inion, death	h occurre	ed at the time, date	e and place,	and due to	the cause(s	)
	To the I	Ž	29b. Signature and title of certifier			29c.	License	number		290	d. Date signed	d (Month,	Day, Year)	
			W. Rivert D.	1 1 -0 1	In Ou	1	20	411	5	11	exem	ber	1,200	06
	S		30. Name and address of person who comp	eleted cause of death	h (Item 23a) (Type, I	Print) 2	01	eu.s	SE/	LAVEI UKG, N	VUE		/	,
			14. ROBERT BICS	CHRACH	mis.	- 2	40	THER	SB	URG, n	W	201	777.	
33	Sta	ite	31. Date filed (Month, Day, Year)	32. Registrar's	Signature									
C	Registr	ar	NOV 6 3 2006	1.	. A	CANA D								

State of Maryland / Department of Health and Mental Hygiene 1 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 257 PM COBBS OCTOBER? 2006 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner If Under 1 Year II Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Year) Baltimore Center NORTHWEST HOSPITAL Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 7-64-7382 11⊠M 2□F Director Usual Residence of Decedent with the Maryland 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at 1 Yes 2 No WOODI Directo 10g. Citizen of What Country? 10e. Street and Number ŏ DOW AVENUE 6 death v Funerai Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after I □ Yes 2 🗖 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 5 1 ☐ Yes 2 No Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 5+ (MASTERS DEGREE SOCIAL SERVICE ADMINISTRATOR BALTO CITY DEPT OF S. S. other 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy important: If Item 27 is marked other eny lighty or other traumatic event 2008. Be 2 19a Informant's Name/Relationship (Type, Print), 19b. Mailing Address (Street and Number or Flural Route Number, City or Town, State, Zip Code) 0000 AUN
Date 20c. Lo 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1. Burial 2 □ Cremation 3 □ Removal from State RBUTUS CEMETERY 11-03-06 ARBUTUS 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Euneral Service Licensee 22. Name and Address of Facility BROWN JR. FUNERAL HOME ULTON AVE. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician Artenoscierotic Cardiovascular /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of) Box 68760 attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant after death.
I Director: After this certificete has been signed by the auxed in by the funeral director, page 2 should be detached for u 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 4☐Pregnant at time of death Division of Vital Records, P.O. 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 Yes 2⊠ No 2 X No 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one. Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ 1 ☐ Yes 2 ② No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: 1 ⊠Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) npletely filled in by 4 Homicide No the Funerel 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier UCTOBER 31, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Randailstown, Maryland BRAUD old court Road CARISTINE ND 5401 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygien 👂 🛭 🕦 💍 34958 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** October 28, 12:01P M 2006 Cynthia Sayer Collins /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Rockville Montgomery Hospice Casey House 8. Date of Birth (Month, Day, Year) Dec. 22, 1952 Washington, DC If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 🗓 F 53 578-76-4016 Director Usuel Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State or 28a-f show 1 ☐ Yes 2 ☑ No Rockville Maryland Montgomery Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö the Medical Examiner must be 1081 Pipestem Place 20854 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after 1 Never Married 2 Married 0 Maryland 21215-0036 1 ☐ Yes 2 🛱 No Specify: Specify. ð 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Education 5+ Teacher 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be and Mentai 27 ie marked traumatic e Geraldine Gatti ဂ္ဂ Charles Sayer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages t end 2 s
Department of Health ar
Important: If item 27 ie
any injury or other trau 1081 Pipestem Place, Rockville, Maryland James W. Collins, Sr./Husband Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition November 1 Donation 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue Rockville, Maryland 20850-2805 All Souls Cemetery 21. Signature of Funeral Service Licence M00803 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Priysician Breast Cancer /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, by Physician/Medical the ettending a 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Dav 4☐Pregnant at time of death 5 Other (specify) signed by the e 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown this certificate has been siral director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 2 No 1 Yes 2 No 1 TYes : After this certification, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 KOther (Specify) Hospice 1 ☐ Yes 2 ☑ No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No death. 2 Accident Director: 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours aft To the Funeral Di completely filled in Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Rynthia M Williams Do H0058032 October 29, 2006 15 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6001 Muncaster Mill Road, Rockville, Maryland Cynthia M. Williams, D.O. 32., Registrar's Signature 31. Date filed (Month, Day, Year) State freel.

DHMH 17 Rev 1/2001

Registrar

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	Physici /Medic		Mary Colos						October		2006	2232 M
1	Examin	er	4a. Facility Name (If not institution, give		4.1		,,	r Location of Death			County of Dea lontgome	
			Shady Grove Adven		(In yrs. last bir	rthday)	Rockvil If Under 1 Year		8. Date of Bir	th		thplace (State or Foreign buntry)
	Funeral Director			□M 2 <b>0</b> F		Yrs.	Months Days	Hours Min.	June 1	6, 19	916 Con	necticut
	p.		Usual Residence of Decedent  10a, State 10b, County		10c. City, Tow	n or Lo	cation					10d. Inside City Limits
	show show	'n										1 ∑Yes 2 No
	the N 28a-f notifie	Director	Maryland   Montgome	il y	Rockv	TITE	10f. Zip Code			10g. Citiz	zen of What Co	ountry?
	3a or	Ö	301 Hurley Avenue	<u>.</u>			20850		ļ	Unit	ed Sta	tes
	ms 2	Funeral	11. Marital Status	12. Was Decedent Ev Armed Forces?	er in U.S.	13. V	Vas Decedent of H	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No		14. Race - Ame Black, Whit	erican Indian,
336	iges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene.  If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	ρ	1 ☐ Never Married 2 ☐ Married 3 🕅 Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	)		Yes 2K No	Specify:	Tiloan, cio.,		Specify:	Thite
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Maryland	ld be ental ked o	To Be	Paul Hladki					Anasta	isia Dat	tsko		
ary	shou and M s mar umat	-	19a. Informant's Name/Relationship (	Type. Print)	19b	o. Mailin	g Address (Street	and Number or Rur	al Route Numb	er, City o	r Town, State,	Zip Code)
ž	and 2		James J. Finzio/N	lephew			•	enue, Roc				20850
Baltimore,	ges 1 t of He If item or oth		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	Removal from State	20b. Place o cemete Russi:	of Dispo ery, crep an (	sition (Name of natory or other place TThodox	ce) Noven	ober 4,		cation - City or	
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			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused to one cause on each line	he death. Do	not ente	er the mode of dyir	ng, such as cardiac	or respiratory a	rrest,		Approximate Interval Between Onset and Death
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	/Medical Examiner		Toolising in cours,	Due to (or as a	consequence	of):						
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	cuted nd ransit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	c								
38760,	cate be executed physician and the burial-transit	a EX	resulting in death) Last	Due to (or as a	consequence	of):						
587		edical		d								
Box (	death certific e attending p d for use as	M/u	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome p		h 2	Ectopic pregnanc	.,		2	23d. Date of de	•
	e death the atte	Physician/M	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4□Pregnant at t			Other (specify)	y			Month	Day Year
P.0	that the	Phy	Part II. Other significant conditions of	ontributing to death but	not resulting i	in the ur	nderlying cause giv	ven in Part I.	23e. Did 1	tobacco u	se contribute t	o the cause of death?
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<u>~</u>	stclan: The law certificate has t rector, page 2 s	Con							1□ Yes	ormed? 2 d No	death? 1 ☐ Yes	s 2□No
Vita	Physician: this certific	Be	25. Was case referred to medical examiner?	Hospital:			t all DOA Oth	26. Place of Deat				
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lon	Attending r death. sctor: After y the fune	tion	Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day	Year)	Injury		rk?  Yes 2 □ No				
Division or Vital Records,	or Attendation of the firm of	Certification:	3 Suicide 6 Could not be determined	28e. Place of injur building, etc.	ry - At home, fa (Specify)	arm, str	eet, factory, office		28f. Location ( City or To	Street an wn, State	d Number or Fi )	lural Route Number,
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical C		nysician: To the best of niner: On the basis of and manner stat	examination ar							
	ro the vithin of the comple	Mec	29b. Signature and title of certifier				29c. Licens	se number		29d. Dat	te signed (Mon	th, Day, Year)
	(1.)		1 Butt Inn	- MD			050	980		Oct	wher	30 2006
	10		30. Name and address of person who	completed cause of de	ath (Item 23a)	(Type,	Print)	. 0	11	1		<b>b</b>
			Brett Gamma 31. Date filed (Month, Day, Year)	MD 9901	Medica r's Signatura	4	eater D:	rive Ko	ckvil	le,	Md. 2	0850
I	St Regist	ate rar	NOV 0 3 2006	May we do	1 603	affe !	,					th, Day, Year) 30 2006

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. I. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Eloise Craigwell 08:45A M 10 30 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Malta House Hyattsville Prince George's If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1 ☐ M 2 ☐ XF 84 Yrs. Director 075-86-5444 09-22-1922 Guyana Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show other traumatic event, the Modical Exercities must be notified at Funeral Director 1 Yes XXNo MD Prince George's **Beltsville** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or Items 23a or 11020 Cedar Lane 20705 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 MNo If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ▼ No <u></u> Specify: Black 3 XWidowed 4 ☐ Divorced "natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry then Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. permit. Pages 1 and 2 should be filed wil Depertment of Health and Mental Hygiens Important: If Itam 27 is marked other the eny injury or other traumatic event Nurse Hospital/Medical 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Louis Daniel McCurdy Barbara Alice Boyce ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11020 Cedar Lane, Beltsville, MD 20705 Jean Craigwell/Daughter 20b. Place of Disposition (Name of cometery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐Donation 5 ☐ Other (Specify) George Washington 11-01-2006 Adelphi, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Marshall's Funeral Home Marshall 4217 9th St NW, Wash. DC 20011 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final **Physician** Acute Cerebrovascular Accident disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Hypertension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner anding physicien and use as the burial-transit To the Hospital or Attending Physician: The law requires thet the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 XNo Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) the 9 Unknown 9 Unknown ģ page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Be Completed by Anemia 1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No Postmenopausal bleeding 24a. Was an autopsy performed? 1□ Yes 2X No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 X Nursing Home 5 Residence 6 Other (Specify) Medical Certification; To 1 ☐ Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA After thi 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 1 X Natural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: , completely filled in by the f 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dev. Year) Rober no D39501 10-31-2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hugh Holder, 101 Stonegate Drive, Silver Spring, MD 20905 31. Date filed (Month, Day, Year) 2006 32 Registrar's Signature State Registrar A 200

			1 - For State Registrar	State of Marylar		artment of H		and Mer		ene 00	6 34961
	<b>A</b>		Decedent's Name (First, Middle, Las	t)				2.	Date of Death	1	3. Time of Death
	Physici		Charles 1	1. Denga	2115				Month		ear 12:35 PM
is.	/Medic Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or	Location o	of Death		4c. County of	
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Q.	Funeral		5. Social Security Number 6. Se	7. Age (In yrs		If Under 1 Year Months Days	If Under 2	24 Hrs. 8. Min.	Date of Birth (Month, Day,		Birthplace (State or Foreign Country)
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Maryland 21215-0036	4 within 72 hours after death with the Maryland Jiene. r than "natural", or Items 23e or 28e-1 ehow the Medical Exartinar must be notified at	by Funeral	1 ☐ Never Married 2 ☐ Married  **X Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Was Decedent of Hi If Yes, specify Cubar 1 ☐ Yes 2 ☑ No		, Puerto Rica	an, etc.)		White, etc.
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nd	O m >	Be	17. Father's Name (First, Middle, Last)							aiden Sumame)	
<u>ya</u>	should by	2	Lawrence DeAngelis				Sa	adie S	alxo		
Jar	2 6 8 3		19a. Informant's Name/Relationship (7	, ,		ng Address (Street a					
	s 1 and 2 if Health item 27 i		June Morris (Daug			Uniontown	n Rd.				
0	Pages 1 nent of H int: If ite iry or ot		20a. Method of Disposition 1 Durial 2 Cremation 3	Removal from State	cemetery, crei	nsition (Name of matory or other place	· 1	Date	7		ty or Town, State
Ë	Pa tmen tent: jury		4 ☐ Donation 5 ☐ Other (Specify			of Faith C			006 1	Baltimor	e, Md.
Baltimore,	permit. Pages. Department of the importent: If ite any injury or of once.		21. Signature of Funeral Service Licens	0 1	7	2. Name and Addres .assahn Fu .401 Belai	neral r Rd.	Home Balt	imore,	Md. 212	36
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<del>ر</del> .	s that ned b	by P	Part II. Other significant conditions co	entributing to death but not re-	sulting in the u	nderlying cause give	n in Part I.		23e. Did toba	icco use contribu	ute to the cause of death?
Division of Vital Records,	quires n sign ald be		Chronic ob	structic	PVI	mmen	dis	ease	1 🗌 Yes	2 No 3	Probably 4 Unknown
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<u>IS</u>	or Attan after deat Director: in by the	fice	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At h	ome, farm, str	eet, factory, office		28f.	Location (Stre	et and Number	or Rural Route Number.
ā	Dir	Cert	4 Homicide	building, etc. (Speci	ry)				City or Town,	State)	
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	To the Hos within 24 h To the Fur completely	Me	29b. Signature and title of certifier			29c. License	number		290	d. Date signed (/	Month, Day, Year)
			MILITER	) hillen		Reg	00	0		11/0	101-
)	1		30. Name and address of person who c	ompleted cause of death (Ite	m 23a) (Type.	Print)				110	100 Landa 12
0	1	8	GitiVa Di	C 10	s A	12 2	tan	M.	05014	4/13/	SIMMUR MO
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** October 10 2006 Mary Dauria /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Shock Trouma Center R Adams Contey Balt Imare Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days 1□M 20 F 291-24-9228 Director Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits r then "natural", or items 23s or 28s-f show the Medical Examinar must be notified at MD Baltimore 1 ☐ Yes 2√ No Rosedale Director 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code within 72 hours after death with 25 Guinevere Court 21237 USA Funeral unk 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11 Marital Status 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: white ð 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 marked other then College (1-4or 5+) 5+ registered nurse healthcare permit. Pages 1 and 2 should be file Department of Heelth and Mental Hy, important: If Item 27 is marked othe eny Injury or other traumatic event, odge. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Frank Dauria Adelina Siani 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2414 Abbeywood Court Clarksville, IN
se of Disposition (Name of Date 20c. Location Johanna Mader/niece Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 ☑Donation 5 ☐ Other (Specify) 21. Signatury of Europea Service Licensee State Anatomy Board 655 W. Baltimore Street Director ill 21201 Baltimore, MD Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 23a. Part . Enter the disease, Immediate Cause (Final disease or condition resulting in death) **Physician** round duy5 /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) CERTIFICATION APPROVED BY METICAL EXAMINER Examiner death certificate be executed physicien and s the burial-transit Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE: for use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year in the past 12 months?
1 Yes 2 No Month 5 ☐ Other (specify) 4□Pregnant at time of death P.0. ete has been signed by the page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records. ğ 1 Yes 2 No 3 Probably 4 Unknown 4 4 pothy revo Completed 24b. Were autopsy findings available prior to completion of cause of death?
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2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 7379 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 22 5 areene Alex Floxmon MD MSE 31. Date filed (Month, Day, Year) 32. Registrar's Signature State NOV 0 2 2006 Registrar

Please Type or Print in Black Indelible Ink.	Ensure All Copies Are Legible
State of Maryland / Department of H	icalth and Mental Hygiene O O

			1 - For State Registrar	State of Maryland	/ Depar	tment of I	Health and I Death		giene) (	006	34963
	Physici	an	1. Decedent's Name (First, Middle, La	,				2. Date of De	ath Day	Year	3. Time of Death
	/Medic	al	Donald Parlett					Nov	01	2006	10=20 AM
	Examin	er	4a. Facility Name (If not institution, giv	0 > /		No.	or Location of Death	1	4c. Cou	unty of Death	
	Funeral		Sinai Hospital o 5. Social Security Number 6.5	Batimore 7. Age (In yrs. las	it birthday)	Baltin If Under 1 Year	II Under 24 HIS.	8. Date of Bir	th	9 Birtho	place (State or Foreign
	Director		220-18-7584	MM 2□F 80	Yrs.	Months Days	Hours Min.	06/02/1	926	Mary	Tand
	pur *		Usual Residence of Decedent  10a. State 10b. County	10c City	Town or Loca	ation					0d. Inside City Limits
)	Maryla f • ho	٥		timore		arkville	3			'	1 ☐ Yes 2 ☑No
3	r 28a	Director	10e. Street and Number	CTIIIOT E	•	10f. Zip Code			10g. Citizen	of What Cour	ntry?
Š	th with	al D	7841 Hillsway Av	renue		21	234		Į	J.S.A.	
2-0036	permit. Pages 1 end 2 should be filed within 72 hours after deeth with the Maryland Department of Heatth and Mental Hygiene. Important: If Item 27 is marked other than "neturel; or Iteme 23e or 28a-f ehow eny Injury or other treumatic event, Ita Medical Examinar must be notified at once.	by Funeral	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U.S. Armed Forces?  1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: WWII		as Decedent of I Yes, specify Cub	Hispanic Origin? (Si an, Mexican, Puerl Specify:	pecify Yes or No Rican, etc.)		Race - Americ Black, White, ecity: Wh	
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Z Z	nd 2 sh lith and 27 is r r treur		19a. Inlormant's Name/Relationship (Douglas W. Dentor				and Number or Ru y Avenue	Baltin			
Je,	of Head		20a. Method of Disposition	20b. Plac	ce of Disposit	tion (Name of story or other pla	ce)	Date	20c. Locati	on - City or To	own, State
Ë	Page nent c ant: If ury or		1 A Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif	w) More	land M		Cem. 11/	04/2006	Balti	more,	Maryland
Baltimore,	permit. Departimport. eny inj		21. Signature 1 Fundral Service (Ser	nsee Charles Miner		nane and Addre	Ruck, Ir			ford Ro , Mary	ad land 21214
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>	Physic this ce al direc	70	examiner? 1 ☐ Yes 2 ☑ No		VOutpatient	3□ DOA Ott	ner: 4 🗆 Nursing H	ome 5 Resi	dence 6	Other (Specify	1)
n o	ding P h. After t funera	inol i	27. Manner of Death  1 ☑ Natural 5 ☐ Pending	(Month, Day Year)	3b. Time ol Injury	28c. Injui	ry at rk?	28d. Describe I			
isic	death death ctor: ,	cat	2 Accident investigation 3 Suicide 6 Could not b		a larm etran		Yes 2 □ No	281 Location (	Stroot and Nu	umbos os Oum	l Route Number,
Div	s after el Direce ed in by	Certification:	4 Homicide determined	28e. Place of Injury - At hom building, etc. (Specify)	o, iaiii, silee	r, ractory, ornes		City or To	vn, State)	mber of Aura	r noute Number,
	To the Hospital or Attending Physician: The law requires thet the death certific within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as	edical	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	ysician: To the best of my knowle niner: On the basis of examination and manner stated.	edge, death on and/or inve	occurred at the ti stigation, in my o	me, date and place, opinion, death occur	and due to the red at the time,	cause(s) and date and plac	manner as st	ated. the cause(s)
	To t To t	Σ	29b. Signature and title ol certifier			29c. Licens	se number		29d. Date sig	gned (Month,	Day, Year)
			chrene	7400		RES	- 000		Nove.	nber (	11 2006
	2		30. Name and address of person who	completed cause of death (Item 2	3a) (Type, Pr	int)					
	Sta	te	Ivene Hao MD 31. Date filed (Month, Day, Year)	32. Registrar's Signatur	al ot	Balti	nove				
	Registr		NOV 0 3 21	006	A STATE OF THE PARTY OF THE PAR	2423					

	,		1 - State Registrar	State of Maryland		artment of H rtificate of L			gienę/ Reg. No.	UUb	34964
	Physici /Medi		1. Decedent's Name (First, Middle, Las CHARLES I	ANIELS				2. Date of De Month	Day	Year 06	3. Time of Death
7	Examir		4a. Facility Name (If not institution, give Future Care-F			4b. City, Town, or Balt:		th	4c. C	ounty of Death	
	Funeral Director		5. Social Security Number 212–42–9778 6. S		st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min	8. Date of Bir (Month, Da 5-11-	th 19, Year) -1942	9. Birthp Coun	lace (State or Foreign try) Md.
	show	٥٢	Usual Residence of Decedent  10a. State 10b. County  Md. NA	, ,	Town or Lo					1	0d. Inside City Limits 11 Yes 2 No
	death with the Maryland ms 23a or 28a-f show Emust be notilled at	i Director	10e. Street and Number 1804 E. 28th Str			10f. Zip Code 21218	3		10g. Citize	on of What Coun	••
920	hours after death tural', or Items 2:	by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 Yes 27 No If Yes, Give Year or Dates:		Was Decedent of Hi. f Yes, specify Cubar	spanic Origin? (S n, Mexican, Puer Specify:	Specify Yes or No to Rican, etc.)		Race - Americ Black, White, pecify: Bla	etc.
Maryland 21215-0036	be filed within 72 ho tal Hygiene. d other then "natur event, itte Mod cal	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12) 7th grade 17. Father's Name (First, Middle, Last)	ucation de completed) College (1-4or 5+)	(Give life.	dent's Usual Occupa kind of work done d DO NOT use retired;	uring most of wo		M S	of Business/Ind	·
yland	2 should be fill and Mental H Is marked ott	To Be	Charlie	Daniels			18. Mother's Na Mary	me (First, Middle,	, Maiden Si	Mason	
	s 1 end 2 should I Health and Men Item 27 Is marke other traumatic		19a. Informant's Name/Relationship (7) Raymond Daniels	Brother	1804	E. 28th	Street,				two.
Baltimore,	permit. Pages 1 end 2 Department of Health a Important: If Item 27 li eny injury or other tra		20a. Method of Disposition  1		ce of Dispo netery, crem inity	sition (Name of natory or other place	)	Date 4–06	20c. Loca	dalk, Mo	
Balt	permit. Departi Import eny inj		21. signature of Funeral Service Licen	Valtery or		Name and Addres	orth Ave		ltimor		21202
ł	Physician /Medical		23a 11. Enter the disease, or come sock, or heart failure. List only of the disease or condition resulting in death)	olications that caused the death.  a					rrest,		Approximate Interval Between Onset and Death
68760,	ificate be executed by g physicien end as the burial-transit as	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a conseque c. Due to (or as a conseque d.	ence or):	9 F T2	act				
P.O. Box 68	wrequires that the death certifics been signed by the attending ph should be detached for use as the	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnand 1 □ Live birth 2 □ Fetal d 4 □ Pregnant at time of dea 9 □ Unknown	eath 3	Ectopic pregnancy Other (specify)			230	d. Date of deliver	ry Day Year
	requires that een signed b nould be deta	ed by Pr	Part II. Other significant conditions co	entributing to death but not resulti	ing in the ur	iderlying cause give	n in Part I.			contribute to the	a cause of death?
Division of Vital Records,	The law re cate has bee page 2 sho	Completed								prior to com death?	esy findings available apletion of cause of
of Vita	hysician this certifical al director	To Be	1 1 1 1 42 5 1 1 40		9/Outpatien		4 Nursing H	ith <i>(Check only o</i> ome 5 ☐ Resid		]Other (Specify,	)
ision	To the Hospital or Attending Physicien: The law Aythin 24 Hours after death.  Aythe Funerel Director: After this certificate has completely filled in by the funeral director, page 2.	Certification:	27. Manny of Death  1	28a. Date of Injury (Month, Day Year)  28e. Place of Injury - At hom	8b. Time of Injury		at ? es 2 □ No	28d. Describe h		ccurred	Pouts Number
Ο̈́	spital or A ours after serel Dire filled in b	al Certi	4 Homicide determined  29a. Certifier 1 Certifying Phy	building, etc. (Specify)  (sician: To the best of my knowledge)			date and place	City or Tow	vn, State)		
	o the Hos ithin 24 h outpletely	Medical	one) 2 Medical Exam	and manner stated.	n and/or inv	estigation, in my opi	nion, death occu	rred at the time,	date and pla	ace, and due to	the cause(s)
			30. Name and address of person who company (Manual Manual	Ompleted cause of death (the S	(2a) /Tues (	(f) (7	537		11-	-1-06	,
	Sta	20-	30. Name and address of person who come address of person who come and address of person who come and address of person who come and address of person who come and address of person who come and address of person who come and address of person who come and address of person who come address of pe	32. Registrar's Signatur	600	W. MOU	N7 Rou	Jal Ave	1 Sa	llo 21	217
	Registr	(6	NOV 0 3	2006 32. Registrar's Signatur	San of						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🛭 🛭 🖯 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Year 40 AM LNOS ean /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HAVRE If Under 1 Year GRACE Home If Under 24 Hrs. Social Security Number Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 M 2 F Hours 218-28-9168 Usual Residence of Decedent 75 Yrs. MÄRYLAND Director 10a. State 10b. County 10c. City, Town or Location ul Hygiene. other than "natural", or Items 23a or 28a-1 show vant, I'ra Madical Examinar must be notified at 10d. Inside City Limits 1 Yes 2 No Directo 10f. Zip Code 10g. Citizen of What Country? Funerai Pages 1 and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 10 17. Father's Name (First, Middle, Last) and Mental ams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) or, Forest Hill Department of Health a Important: If Item 27 Is sny injury or other tree once. nobloc 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other p 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Evans Funeral Chasel-Belfir Forest Hill, ND 21050 holka EVANS FUNERAL CHAPEL + CREMATION SERVICES BELAN 23a. Part 1. Enter the dispase, or complications that cal shock, or heart failure. List bry one cause on ear ed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) dration **Physician** LUK /Medical Due to (or as a consequence of) Examiner advanta if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or s a consequence of). Examine The law requires that the death certificate be executed physicien and resulting in death) Last Due to (or as a consequence of) P.O. Box 68760, Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No
9 Unknown 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4□Pregnant at time of death 5 Other (specify) signed by the at Id be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Dew 3 Probably 4 □Unknown 1 🗌 Yes 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No cate has l autopsy performed? res 2 No within 24 hours after death. To the Funeral Director: After this certificate I completely filled in by the funeral director, pag 1 ☐ Yes 25. Was case referred to medical examiner? Medicai Certification: To Be 26. Place of Death (Check only one) 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 1 Tyes 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Numan 3260 in) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Kear)

Muhrun to nocker elution St

32. Registrar's Signature

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		·	For State Registrar		State of N	narylar			of Health and of Death	Mental Hy	/giene Reg. No.	4000	34966
	Physicia		1. Decedent's Nam	e (First, Middle, L Helen		ravis		Edv	ards	2. Date of D Month	eath Day 26	y Year 2006	3. Time of Death 9:30p M
	/Medic Examin			If not institution, g	ive street and numbe			4b. City, To	wn, or Location of De		-T-	County of Death	1
	Funeral Director		Manor 5. Social Security N 218–18–0	Number 6. 704	Dulaney Sex 7.7 1□M 2【XF	Age (In yrs.	last birthday) Yrs.	If Under 1					pplace (State or Foreign intry) Va.
	/land		Usual Residence o 10a. State	f Decedent 10b. County		10c. Cit	ty, Town or Lo	cation					10d. Inside City Limits
	e Man	Director	Md.	N	A		Bal	timore					Y Yes 2 No
	3a or 2	ai Dire	10e. Street and Nu 4607 Li		ight Heigh	nts Av	æ.	10f. Zip Co			10g. Citi	izen of What Cou USA	untry?
020	s I and 2 should be filed within 72 hours after death with the Maryland I Health and Mealth Hygiene. I Health and Mealth Hygiene. I them 27 is marked other then "naturel; or Items 23a or 28a-f show other traumatic event, II:a Mealtal Exand at miral be I criffied at	by Funeral	11. Marital Status	ried 2 Marnied	12. Was Deceder Armed Force: 1  Yes 2 If Yes, Give Year or Dates	nt Ever in U ? No	.S. 13. V	Vas Deceden f Yes, specify ☐ Yes 2∑	of Hispanic Origin? Cuban, Mexican, Pue No Specify:	(Specify Yes or Nerto Rican, etc.)	0-	14. Race - Amer Black, White Specify: B	
ה ה	n 72 ho "natur edicel	Completed		15. Decedent's l cify only highest g	Education rade completed)		(Give	lent's Usual C kind of work of OO NOT use i	one during most of w	vorking	16b. Ki	ind of Business/li	ndustry
7   7	ed withii /giene. ier then t, the M	Comp	Elementary/Second 12th gr	ade	College (1-4o	r 5+)			Operator			Howard	Hosp.
=	2 should be filed within and Mental Hygiene. Ie marked other then aumatic event, Ite Me	To Be	17. Father's Name Garfiel			Water	3		18. Mother's N	ame (First, Middle NY	e, Maiden		ith
_	2 should and Men and Men is marke		19a. Informant's N						reet and Number or i				
ע	os 1 and 2 of Health filem 27 rother tra		Kim Wate 20a. Method of Dis	position	Niece	20b. F	2303 Place of Dispos cemetery, cren		ley Dr., l	Date		ocation - City or T	
	permit. Pages Department of Important: If it any injury or o		4 Donation	5 Other (Spec		G G	arrisor	n Fores	t Vet. 11	-6-06	RAN	DALLSTO	WN, MD.
0	Departiment important		21. Signature of Fu	uneral Service Lice	ensee Walk	ne I			ddress of Facility . North Av	March e., Balt			21202
			snock, or nea	artallure. List on	nplications that caus y one cause on each	ed the deat line.							Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause disease or condition resulting in death)	on	a. Ne Due to (or a	na.	uence of):	tail	une war d				
	Examiner	-a	Sequentially list co	onditions,	b. Pero	Phe s	vence of):	Vasc	war o	liseas	e .		
	scuted tnd transit	Examiner	cause. Enter Under Cause (Disease or that initiated events resulting in death)	injury	c. Die	abe	tes	Mei	itus				
,00700	rcate be executed physicien and s the burial-transit	edical Ex	resulting in dealing	Last	Due to (or a	s a conseq	uence ot):						
00	ertificat ling phy e as the	Medi	IF FEMALE:										
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 54 brouss after death.  To the Funeral Director: Attent this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/M	23b. Was deceden in the past 12 1 Yes 2 9 Unknown	months?	23c. If yes, outcom 1 □ Live birth 4 □ Pregnant 9 □ Unknown	2 Feta	l death 3 🗌	Ectopic pregr Other (special			2	23d. Date of deliv Month	very Day Year
olds, r	quires tha	ě	Part II. Other signi	ficant conditions	contributing to death	but not res	ulting in the ur	derlying caus	given in Part I.		tobacco u Yes 2[		the cause of death? bably 4 Minknown
מט	has bee	Completed						· <del>-</del> ·		24a. Was		24b. Were auto prior to co death?	opsy findings available ompletion of cause of
<u> </u>	ian: Ti rrificate ctor, pa	Be Co	25. Was case refer	rred to medical					26. Place of D		2 40		2 <del>□ N</del> 0
5	hysic this ce al dire	P	1 ☐ Yes 2 🔀	-			ER/Outpatient			Home 5 ☐ Res			ly)
5	inding Path. r: After i	atlon:	27. Manner of Deat 1 ⊠Natural 2 ☐ Accident	th 5 Pending investigation	28a. Date of In (Month, E	jury a <i>y Year)</i>	28b. Time of Injury	28c.	Injury at Work? 1 □ Yes 2 □ No	28d. Describe	how injur	y occurred	
2	To the Hospital or Attanding Physician: The law within 24 burus after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could not determine	d 28e. Place of I	njury - At he atc. (Specif		eet, factory, of	ice		Street and wn, State,		al Route Number,
	Hospite 24 hours Funera	Medical C	29a. Certifier (Check only one)	1 Certifying F	hysician: To the besiminer: On the basis and manner:	of examina	wledge, death tion and/or inv	occurred at t	ne time, date and plac my opinion, death oc	ce, and due to the curred at the time	cause(s) date and	and manner as s	stated. to the cause(s)
	To the	Me	29b. Signature and	A	1.				cense number	1011		e signed (Month,	
				ress of person who	o completed cause of	death fitten	23a) (Type 5		00544	127	11	- 2 - 0	06
	7		Cyru	s Asa	di, 20,	E.T.	moni	um	rd. suite	209	Tim	roncun	Mn 2109
	Sta		31. Date filed (Mon	ntn, Day, Year)	200 32. Regis	trar's Signa	iture	Angel !					

State of Maryland / Department of Health and Mental Hygiene 0 6 1 - State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 8:30 AM M 29, 4a. Facility Name (If not institution, give street and number) October 2006 /Medical 4c. County of Death 4b. City, Town, or Location of Death Examiner 3310 Leisure World Blvd. #715 Silver Spring Montgomery 9. Birthplace (State or Foreign Country)
CT II Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Month, Day, Year) 02/14/1928 1**X** M 2□ F Months 78 577-34-4404 Yrs. Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits th and Menial Hygiene. 7 is marked other then "natural", or iteme 23s or 28s-1 ehov traumatic event, the Medical Examble moust be notified at 28a-f ehow MD 1 ☐ Yes 2 No Director Montgomery Silver Spring 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 3310 N. Leisure World Blvd. 20906-#715 United States death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. permit. Pages 1 and 2 should be filed within 72 hours after c Department of Heelih and Mentat Hygiene. Important: If Item 27 is marked other then "natural; or Item eny Injury or other traumatic event, the Medical Exam. A Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Construction Elementary/Secondary (0-12) College (1-4or 5+) Estimator 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Thomas J. Farley Marie M. Ries 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20906 Cecilia M. Farley/Wife 3310 Leisure World Blvd. #715; Silver Spring, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 11/1/20061 ☐ Burial 2 X Cremation 3 ☐ Removal from State Chesapeake Crematory Inc. Beltsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) M00382 22 Name and Address of Facility Rapp Funeral & Cremation Services Silver Spring, Maryland 20910-23a. Part1. Enter the disease, or complications that caused the death. So not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 933 Gist Ave. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Non Small Cell Lung Cancer **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to minimaliate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a nonecquaries of): Examine Hospitel or Attending Physician: The law re-uires that the death certificate be executed nding physicien and use as the burial-transit Due to (or as a consequence of): P.O. Box 68760, Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 ☐ Ectopic pregnancy Month Year Day 4 Pregnant at time of death 5 Other (specify) 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐Unknown 24b. Were autopsy lindings available prior to completion of cause of death? 24a. Was an has autopsy rmed? 21 No 1 Yes 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death | Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA 1 Yes 2 No 2 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred Certification: After 1 Natural 2 ☐ Accident Injury 5 Pending death. 1 ☐ Yes 2 ☐ No | Director: A investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) 28I. Location (Street and Number or Rural Route Number, City or Town, State) filled in by after 4 - Homicide within 24 hours at To the Funerel D completely filled i 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edicai 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Paul Banner MD060335 October 30, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Paul A. Bannen M.D. 18111 Prince Philip Dr. #327, Olney, MD 20832 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

			For State Registrar		State of Ma	arylan	id / Depa <i>Cer</i>	irtmen <i>tificati</i>	t of Hea e of De	alth and M eath		giene Reg. No		3496	8
	Physici /Medic			ne (First, Middle, Las 11iam B		s S	Sr.				2. Date of Dea Month NOV	ath Day	<sup>y</sup> 2006 <sup>Year</sup>	3. Time of Death	
	Examin			(If not institution, give	street and number)			4b. City,	Town, or Lo	ocation of Death		4c.	County of Dear		
			5. Social Security N	go Court	2 7 An	a (In vrs	last birthday)	If Under	Ess 1 Year   I	ex Under 24 Hrs.	8. Date of Birtl		Baltim		ion
	Funeral Director		216-34-		<b>⊠</b> M 2□F		59 Yrs.	Months		Hours Min.	May 2	/, Year)	37 Ohi	hplace (State or Fore ountry)  O	igri
pu			Usual Residence of	of Decedent 10b. County		10c Cit	y, Town or Lo	cation						10d. Inside City Lim	ite
Maryla	o e ho	Į.	MD	Baltim	ore	100.01	Essex							1 □ Yes 2 □ X	
the	r 288-	Director	10e. Street and Nu	<u> </u>				10f. Zip	Code			10g. Cit	izen of What Co	ountry?	
th wit	23a o	alD	2 Ming	go Court				2	1221			U	SA		
u K. K. I. J. 2000 illed within 72 hours after deeth with the Maryland	f Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23a or 28a-f ehow other traumatic event, Ita Medical Examiner must be notified at	by Funeral	11. Marital Status 1 ☐ Never Man 3 ☐ Widowed	ried 2⊠ Married 4 □ Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates:		-	Was Deced f Yes, spec l ☐ Yes		anic Origin? (Sp Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		14. Race - Ame Black, Whit Specify: W		
2 hou	ical E	ted		15. Decedent's Ed	ucation		16a. Deced	lent's Usua	I Occupation	on ing most of work	ina	16b. K	ind of Business	Industry	
d within 7	Health and Mental Hygiene. tem 27 is marked other than "r other traumatic event, Ina Mad	Completed	Elementary/Second 10th		College (1-4or 5	i+)	Bric			ng most of work	mg	Om	era Co	nstructi	on
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98 1.9	of Hear Fitem r othe		20a. Method of Dis			20b. F	Place of Dispos	sition (Nan	na of		Date	20c. Lo	ocation - City or	Town, State	
Peo	tment tant: I jury o		4 Donation	5 ☐ Other (Specify	)	OF	Ak Law				6/06	Bal	timore	MD	
	Department of Heal Important: If item eny injury or other once.		21. Signature of F	uneral Service Usen	alle		22		d Address on the contract of t	30	0 Mace al Hom			to. MD x 21221	
			23a. Part 1. Enter shock, or hea	the disease, or comp art failure. List only	olications that caused one cause on each lin	I the deat ne.	h. Do not ente							Approximate Interval Between Onset and Death	,
	nysician Medical		Immediate Cause disease or conditi- resulting in death)	on	a. ~4	- 4	Can	cer						8 mmth	<u>~</u>
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ate be	nysicia he bur	edical		•	d										
Sertific	ding p	/Mec	IF FEMALE.		23c. If yes, outcome	of pregna	ancy								
To the Hospital or Attending Physician: The law requires that the death certif	y the ettending ched for use a	Physician/M	23b. Was deceder in the past 12 1 Yes 2 9 Unknown	2 months? □No	1□Live birth 4□Pregnant at 9□Unknown	2 Feta	Ideath 3	Ectopic pro Other (sp.					23d. Date of del Month	Day Year	
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£ ::	this certificete heral director, page	e Co	25. Was case refe	urad to medical								med? 2 No	1 Yes	2 □ No	
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Tal or A	rs after si Directed in by	Certif	4  Homicide	determined	building, et	c. (Specif	y) 				City or Tow	n, State	)	iral Route Number,	
ne Hosp	within 24 hours after death.  To the Funeral Director: After completely filled in by the funer	Medical	29a. Certifier (Check only one)	1 Certifying Ph	ysician: To the best of the basis of and manner sta	examina	wledge, death ition and/or inv	occurred restigation,	at the time, in my opini	date and place, on, death occurr	and due to the c red at the time, o	ause(s) late and	and manner as place, and due	stated. to the cause(s)	
Tot	To the	Σ	29b. Signature and	when of certifier	bu hert.	12	11	290	License no	356	2	29d. Dat	te signed (Monti	h, Day, Year)	
	h		30. Nanhe, and add	lress of person who	completed cause of d	eath (Iteg	n 23a) (Type,	Print)	<i>y</i> - '	1	.~	0		21237	
	)		Willian	n ( Wa	ater fie	110	9103	tro	ink,	lin Sq	·10r.	2,4	.2200	Da Ho. M.	)
	Sta		31. Date filed (Mor	nth Day, Year)	006 32. Registra	ar's Signa	iture	23462	P	0					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 0 5 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Walter Dwight Fuller October 31, 2006  $A^{M}$ 6:15 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Shady Grove Adventist Hospital Rockville Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)

April 6, 1911 6. Sex 1 ☑ M 2 ☐ F 9. Birthplace (State or Foreign Country) Maine 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Yrs 95 006-18-6119 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23s or 28s-f show other treumatic event, the Modical Exactional temporal be modified at 1 ☐ Yes 2 X No Directo Maryland Montgomery Germantown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20916 Theseus Terrace 20876 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No λ Specify: White 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) e filed withir al Hygiene. other than Mechanic Farm Machinery permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 te marked othal eny Injury or other tremment. 18. Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First Middle Last) Walter Scott Fuller Lillian Kneeland 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sarah Fuller (Daughter) 20916 Theseus Terr., Germantown, MD 20876 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Estes Park Cemetery 11/4/05 Easton, Maine 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License, 22. Name and Address of Facility Duncan-Graves Funeral Home, Inc. Mein 30 Church St., Presque Isle, Maine 04769 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition **Physician** Stroke /Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner death certificate be executed ettending physician and I for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No detached 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 🖾 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 🛣 No 2 ER/Outpatient 3 DOA Inis filled in by the funeral 27. Manner of Death 1 ANatural 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification; After Hospital or Attending 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after deat • Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier and manner stated. within 2

State Registrar

29b. Signature and title of certified

Brandon 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Falk

NUV

0 3 2008

9901

32. Redistrar's Signature

Baltimore, Maryland 21215-0036

P.O. Box 68760.

Records.

Division of Vital

29c. License number

29d. Date signed (Month, Dey, Year)

D0064029 Oct 31,2006

Center Drive Rockville, MD

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2006 34970 Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2 Date of Death Month **Physician** Deborah ex 10591 Furrow 30 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BUYER olew Under 24 Hrs. 8. Date of Birth (Month, Day, Year) May 6 1950 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 1□M 2□ F 214-56-1566 56 Director Maryland Usual Residence of Decedent the Maryland 10c. City, Town or Location Glen Burnie 10a. State 10b. County 10d. Inside City Limits 7 is marked other then "nstural", or items 23a or 28a-f show traumatic event, the Medical Examinar must be notified at Anne Arundel Maryland 1 ☐ Yes 2 X No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 72 hours after death with Harbour Way #3B USA 1106 Castle 21060 Funeral 12. Was Decedent Ever in U,S. Armed Forces?

1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 3altimore, Maryland 21215-0020 1 ☐ Yes 2 ☐xNo Specify: Specify: White ģ 3 ☐ Widowed 4 X Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry d 2 should be filed within 72 th end Mental Hygiene. 7 is marked other then "ne Elementary/Secondary (0-12) College (1-4or 5+) Travel Agent Travel Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Clayton Howard Willard Frances 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health enc important: If Item 27 is n Holly Hill daughter 16313 258th Ave. Southeast Issaguah Wash. 98027 20a. Method of Disposition
1 □ Burial 2 ☑ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 11/2/06 Baltimore Maryland Metro Crematory INC 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Stallings Funeral Home P.A. at the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

| Approximate | Interval Between | Onset and Death | 23a. Part1. Enter the disease, or conshock, or heart failure. List only **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical erioscherotic Heart Disease Examiner Examine Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last the buriel-tran Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of deeth? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 5 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 1 Tes 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: ဥ 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural 2 Accident 5 Pending investigation 1 Yes 2 No Director 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Mospitei or At 24 hours efter of 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical To the 29b. Signatuse and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Deputy person who completed ca se of death (Item 23a) (Type, Print) ones

State Registrar

NOV 0 3 2006

Milliam

31. Date filed (Month, Day, Year)

32. Registrar's Signature

OELSARS PRENCH

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TTEM#3829d perPHYS G861 11/3/06 WS
State of Maryland Department of Health and Mental Hygien 0 0 6 1 = For State Registrar Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** 10 Dolores Marie French 30 06 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Square Baltimore FRANKIN KOSEdalE HOSDHAI 5. Social Security Number 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1 ☐ M 2 🔀 F Director 218-22-9392 78 18,1927 Maryland Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28e-f show traumatic event, the Madical Examiner must be notified at 1 Yes 2 No Director Maryland N/A Baltimore City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 1009 Hewitt Way or Items 23a 21205 United States Pages 1 and 2 should be filed within 72 hours after death Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puento Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2€No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: 3 Widowed 4 Divorced Year or Dates: "nature!" White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 10 Years Telephone Sales Pharmaceutical Co. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ls marked o John B. French Katherine Hollins 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Charles French (Son) item 27 1672 Yakona Road Baltimore, Maryland 21286 other 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition 0 = cemetery, crematory or other place) ō 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State permit, Page Department of Important: If eny injury or once. Wew/Cathedral Cem. 4 □ Donation 5 □ Other (Specify) 11/2/2006 Baltimore, Maryland 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc. 21. Simature of vieral Servici Licensee 7922 Wise Ave. Dundalk, Maryland Part Enter the disease, or complications that caused the dishock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death eath. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final **Physician** Due to (or as a consequence of): disease or condition resulting in death) /Medical Examiner D ELacer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit neumonia Box 68760, Due to (or as a consequence of). Physician/Medical the as IF FEMALE: for use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) o be detached 9 Unknown 9 Unknown م Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. þ 1 Yes 2 No 3 Probably 4 Qunknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2屆 No 24a. Was an 1 ☐ Yes of Vital 2 🛛 No Be funeral director 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No Certification: To 1 Nanpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After Division 1 Natural
2 ☐ Accident Injury 5 Pending efter death. Director: Af 1 ☐ Yes 2 ☐ No investigation the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours e To the Funeral C 1 Certifying Phylician: To the best of my knowledge death conumed at the time, data and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier completely (Check only th st 29b. Signature and 29c. License number 29d. Date sighed (Month, Day, Year) · 10/30/2006 Kes 00000 30. Nuf completed cause of death (Item 23a) (Type, Print) enter, 400 Farklin Square 31. Date filed (Month 32. Régistrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 👂 🛭 🗎 🖯 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death **Physician** October 27, 2006 Bernice Olivia Gary /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Apt. 803 Howard Columbia 5400 Vantage Point Rd. If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye 7/24/18 9. Birthplace (State or Foreign Country)
Georgia 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Hours Days 1 □ M 2 X F 88 Director 253-16-5140 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or Items 23s or 28s-f show the Medical Examiner must be notified at Be Completed by Funeral Director 1 ☐ Yes 2 ☑ No Columbia Md Howard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21044 USA 5400 Vantage Point Rd. Apt. 803 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ∐Yes 2 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 M Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry is marked other than Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Injury or other traumatic event, permit. Pages 1 end 2 should be file Department of Health and Mental Hy Important: if Item 27 is marked oth any lighry or other traumatic event 2008. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Alice Olivia Davis Burchard Brickman Berry 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5400 Vantage Point Rd. Apt. 803 Columbia, Md. 21044 Mr. Laurence H. Gary / Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 □ Other (Specify) Loudon Park Cemetery | 11/1/06 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Loudon Park Funeral Home 3620 Wilkens Ave. Baltimore, Maryland 23a. Part1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** neumonia /Medical Due to (or as a consequence of) ension-uncontrolled Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner been signed by the attending physicien and should be datached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of). Division of Vital Records, P.O. Box 68760, Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 1 Live birth 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? lite initialant 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed? 1 ☐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2 No Other: 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of Medical Certification; 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide To the Hospital within 24 hours e To the Funeral Completely filled in Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number Bell lane Clarksulle MD 21029 30. Name and address of person who completed cause of death (Item 23a) (Type, Print), SU2AM ABOO 5005 Signal 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 3 2006 Registrar

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			1 - For State Registrar	State of Mary				and Mental	Hygien	<b>2</b> 006	34973
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П	Physici	an	1. Decedent's Name (First, Middle, Las		<b>a</b> 1		-	2. Date	of Death	ay Year	3. Time of Death
	/Medic	al		nry	Gerk		Jr.		0	2006	8:35AM
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	e Ma	ç	Maryland Baltimo	re	Colo	gate					1 □ Yes 2X No
	or 28	Oire	10e. Street and Number			10f. Zip (			10g. C	Citizen of What Co	ountry?
	should be filed within 72 hours after death with the Maryland ud Mental Hygiene. marked other than "natural", or liema 23a or 28a-f ahow matic event, the Modical Exeminat must be notified at	Funeral Director	8007 Wynbrook Roa	<b>a</b>		2	224		I	USA	
	en de	au P	11. Marital Status	12. Was Decedent Ever Armed Forces?	in U.S.	<ol> <li>Was Deceded</li> <li>If Yes, specified</li> </ol>	ent of Hispanic Orig by Cuban, Mexican,	gin? (Specify Yes , Puerto Rican, et	or No- c.)	14. Race - Ame Black, Whit	
36	or l	by Fi	1 Never Married 2 Married	tv Yes 2 □ No If Yes, Give		1 ☐ Yes 2			·	Specify: W	
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Ϋ́	"na"	ete	15. Decedent's Ed (Specify only highest gra		16a. De	icedent's Usual ive kind of work	Occupation done during most retired)	of working	166.	Kind of Business	Industry
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2	filed Hygi ther ant,		17. Father's Name (First, Middle, Last)		50	eel wor		r's Name (First, N		ntinenta en Sumame)	ı can
a	ould be Mental arked o	To Be	Earl Henry Gerke	Sr.				rie Bens		,	
Maryland	shound Mari	-	19a. Informant's Name/Relationship (		19b. M	ailing Address	Street and Number			or Town. State.	Zin Code)
	permit. Pages 1 end 2 should Depertment of Heelth and Mer Important: If Item 27 is marks eny injury or other traumatic once.		Shirley Gerke	Wife			ook Road				21224
<u>ნ</u>	f Heer fem othe		20a. Method of Disposition	2	0b. Place of Di	sposition (Name	e of	lovenber		Location - City or	
Ê	Pages nent of int: If It iry or o		1 XBurial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specific	Removal from State	Oak Lav	n Cemet		, 2006	Dui	ndalk, M	D <b>.</b>
Baltimore,	permit. Page Depertment of Important: If eny Injury or once.		21 Signature of Funeral Service Licer	1		22. Name and					
ä	Deperment of the perment f the permet of		Alies mos	1/2		7110 Sc	y Funera 11ers Po	ii Home C int Road	i Duna I. Duna	dalk, P., dalk,Md.	<sup>A</sup> . 21222
П			23a. Fart1 Enter the disease, or com- spook, or heart failure. List only	plications that caused the	death. Do not				<u> </u>		Approximate
	hysician		Immediate Cause (Final	Dec	pirat	SVII	`				Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	a. Due to (or as a co	nsequence of):	7 9	ailure				
	Examiner			Emi	shuse	ma.					
7		ner	Sequentially list conditions, if any, leading to immediate	Due to (or as a co	nsequence of):	11 100					
57	cuted	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	C.							
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-	ys 96	icai		d							
89	The law requires that the death certificat site hes been signed by the ettending phy bege 2 should be detached for use as the	Physician/Med	IF FEMALE:		2010						
Вох	ath ce	an/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pr	Fetal death	3 □Ectopic pre				23d. Date of de	•
o O	e de the e	sic	1 Yes 2 No	4□Pregnant at time 9□Unknown	of death	5 Other (spe	city)			Month	Day Year
<u>a</u> .	that the de ned by the e detached t	F B	Part II. Other significant conditions of	ontributing to death but or	at cooulting in th		usa musa is Dad I	220	Did tabassa		
က်	ires tha signed d be del	þ	Esophageal	carcinor	_	e underlying ca	use given in Part I.	236.			the cause of death?
Records,	w require	Completed	District	11:10:	rec				Tes	2 NO 3 P	obably 4 Unknown
Sec Sec	e law hest e 2 s	n pi	Diabetes m	ellitus				24a.	Was an autopsy	prior to	topsy findings available completion of cause of
								10	performed? Yes 2 1		2 No
Vital	icien Certifi ector	Be	25. Was case referred to medical examiner?	Hospital:				of Death (Check	only one)		
<u></u>	Attending Physicien: The laving death. ector: Alter this certificate hes by the funeral director, pege 2	၉	1 ☐ Yes 2 ☑ No 27. Manner of Death	1 M Inpatient	2 ER/Outpa			rsing Home 5			cify)
5	Jing After fune	5	1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Ye	ar) 28b. Tim Inju	y M	c. Injury at Work?		cribe now inj	jury occurred	
2	- 0 1	ica	2 Accident investigation 3 Suicide 6 Could not b		At home, farm		1 Yes 2 N		tion /Ctm at	and Mushau an D	ural Route Number.
Division	after Dire	Certification:	4 Homicide determined	building, etc. (S	pecity)	Street, laciory,	Office		or Town, Sta		arar Houte Number,
_	To the Hospital or At within 24 hours after of To the Funerel Direct completely filled in by		29a. Certifier 1 Certifying Ph	lysicien: To the best of m	y knowledge. d	ath occurred a	the time, date and	d place, and due t	o the causo	(s) and manner as	stated
	24 h 24 h Fui etely	Medical	(Check only 2 Medical Examone)	niner: On the basis of exa	mination and/o	investigation, i	n my opinion, deat	th occurred at the	time, date a	nd place, and due	to the cause(s)
	roth Mithin roth Somp	Me	29b. Signature and title of certifier			29c.	License number		29d. D	Date signed (Mont	h. Day, Year)
}	-1-9		Mrs A	Tomelow do	)		218	46	j	1/1/11	
			30. Name and address of person who	completed cause of death	(Item 23a) (Ty	pe, Print)				1.108	)
_	10		Dr. Martin SI	zeridan 9	000 F	rankli	nsqua	re Dri	Ve I	Baito. 1	ND 21237
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's	Signature	-					
4.	Registr	20	10(11)/ /3 3	ATTEND OF A	E.M	AT AL	T-				

		•	1 - State Registrar	State of	Marylar				lealth a Death			gien Reg. N	2000	5	34974
			1. Decedent's Name (First, Middle, Las	it)							2. Date of De	ath			3. Time of Death
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	Medio/ Examin		4a. Fecility Name (If not institution, give				4b. Cit	y, Town, o	r Location		000000		c. County of E		0.02 1.
		•	3626 Ash Street					Balt	imore					N/I	Δ
Fı	uneral		Social Security Number     6. Security Number		. Age (In yrs.	last birthday)		er 1 Year	If Under	24 Hrs.	8. Date of Bir	th	9.		ace (State or Foreign
	rector		218-30-6996	M 2□F	71	Yrs.	Month	s Days	Hours	Min.	(Month, Da March		1935 C	inuos LLVC	ngton, VA.
P			Usual Residence of Decedent												
ylar	P P		10a. State 10b. County			ty, Town or Lo								10	Od. Inside City Limits
Ď Đ		5	Maryland N/	A	E	Baltimo	re								12 Yes 2 No
댪	or 2	Funeral Director	10e. Street and Number				10f. 2	ip Code			8	10g. C	itizen of Wha	t Count	try?
# th	238	la	3626 Ash Street						21211				ited S		
de de	E H	au l	11. Marital Status	12. Was Deced Armed Ford	es?	J.S. 13. 1	Was Dec	edent of H	lispanic Or an, Mexica	igin? (Spec	cify Yes or No Rican, etc.)	)-	14. Race - A Black, V		
s afte	9	<b>by</b> Fu	1 ☐ Never Married 2 ☐ Married	1 ☐ Yes 2 If Yes, Give	_			2X No	Specify:				Specify:	Wh	
Supply Su	and Marie		3 H Widowed 4 □ Divorced	Year or Dat	les:							1			
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Hygied A	nt, m		17. Father's Name (First, Middle, Last)	n/a		PLO	auce	Mana	_	er's Name	(First, Middle	-	P Super	L l <sup>v</sup> lc	arket
d be fill	0 pe	Be	Lloyd Halterman									, ,,,,,,,,,	ar obmano,		
ary iand ZIZI3-UU30 should be filed within 72 hours after death with the Maryland nd Mental Hygiene.	mark	ပ္	19a. Informant's Name/Relationship (	Type Printl		19h Mailir	ng Addra	es (Straat		na Wa		er City	or Town, Sta	te Zin	Codel
Mar d 2 sho th and	7 is trau		Youlanda L. Halte		uach+or		-								
Heelth	em 2		20a. Method of Disposition	Illan (Da	20b. f	Place of Disco	sition /A	ame of			imore,		Ly Land Location - City		L211 wn. State
Pages Pent of	i if it		1 ☐ Burial 2 ☐ Cremation 3 ☐		tate	cemetery, crer	natory o	other plac	1 1	Jov. 4	,2006				
CALLITION TIMIT. Pages pertment of	mportant: if item 27 is marked other than "natural", or items 23s or 28s4 ebov any injury or other traumatic event, <u>tra Medical Exactinar must be notified at</u> 20cs.		4 ☐ Donation 5 ☐ Other (Specify 21. Signature of Funeral Service Licen		Eve	ns Fun									l,Maryland
Deperm Depe	any in		Jeffrey J	. gair	, Dr.	. Pé	acef 25 Y	ul A. Ork	Iterna Road	ătive Tim	s Fune	ral Ma	&Crematryland	tior	n Ctr.,P.A. 21093
			23a. Part. Enter the disease, or com- shock, or heart failure. List only	plications that car	used the deal	th. Do not ent	er the m	ode of dyir	ng, such as	cardiac or	respiratory a	rrest,	•		Approximate Interval Between
Phy	sician		Immediate Cause (Final disease or condition	177	HERO	SCL	000	110	11/3	404	17:5	100			Onset and Death
	edical		resulting in death)		r as a consec			1 -	[1	4 IC	7310	, – –	. 3 C		
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/ D	#	Examiner	if any, leading to immediate cause. Enter Underlying	Due to (o	r as a consec	quence of):									
ecute	trans	me	Cause (Disease or injury that initiated events resulting in death) Last	c										_	
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ertific o	ding be as	We.	IF FEMALE:	22- 11		Tel.									
ath cer	or us	lan	23b. Was decedent pregnant in the past 12 months?		th 2 ☐ Feta	aldeath 3□		pregnancy	у				23d. Date of Month		ry Day Year
	been signed by the ettending p should be deteched for use as	by Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4∐Pregna 9☐ Unknov	nt at time of o wn	death 5	Other (	specify) _							,
T ta	d by Jetec	F.	Part II. Other significant conditions of	ontributing to dea	ath but not res	sulting in the u	nderbing	Cause div	en in Part I		23e Did	tobacco	use contribut	te to the	e cause of death?
RECOLUS, he law requires t	signe d be	b	SUPRAVER												ably 4 Munknown
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e a v	2 8	J du	COPD								24a. Was auto	psy	24b. Wer	to com	sy findings available apletion of cause of
_ F	is certificete hes director, page 2	ပိ									1 ☐ Yes	2 ZN	deat lo 1 □	n? Yes	2[X]No
OI VILAI Physician: T	ector	Be	25. Was case referred to medical examiner?	Hospital:						e of Death	(Check only	one)			
		2		Hospital: 1 ☐ In		ER/Outpatier		JOA ]					6 ☐Other (	Specify	)
E I	After	on	27. Manner of Death 1 Natural 5 ☐ Pending	1	, Day Year)	28b. Time o		28c. Injui Wor	rk?		8d. Describe	now in	ury occurred		
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DIVISION Cal or Attending P	Direc I in by	Certification:	4 Homicide determined	building	g, etc. <i>(Speci</i>	nome, farm, str ify)	eet, fact	ory, office		2	City or To	wn, Sta	te)	r Hura.i	Route Number,
spita	y filled		29a. Certifier 1 Certifying Ph	ysician: To the t	pest of my kno	owledge, deat	h occurre	d at the til	me, date ar	nd place, a	nd due to the	cause(	s) and manne	r as sta	ated.
the H	To the Funeral Director: After this completely filled in by the funeral di	Medical	(Check only 2 Medical Exam	and manne	sis of examina er stated.	ation and/or in				ath occurre	ed at the time,				
o ₹	T 00		29b. Signature and title of certifier	\ =			1		se number				ate signed (N		
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	12		30. Name and address of person who					-0.15					2015	η	
			SINDIFU JAN 31. Date filed (Month, Day, Year)			YO/LIC			L4 1	14 612	V1 L L C		MID	7(	593
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			State Amend Items	State of Maryland / De 23a,25,27,28a-f pe	partment of Health and r ME 6861 11/02/00 ertificate of Death	Mental Hygien Xdhb Reg. N	2006	34975
			1. Decedent's Name (First, Middle, La			2. Date of Death	ay Year	3. Time of Death
	Physici /Medic		DARYL HI	ART		SEPTEMBER	,	7:57 AM
	Examin		4a. Facility Name (If not institution, gi		4b. City, Town, or Location of Deat	h 4	lc. County of Death	
			HARBOR HOS  5. Social Security Number 6.	Sex 7. Age (In yrs. last birthda	BALTIMORE  av) If Under 1 Year   If Under 24 Hrs		BALTIMO	ICE (State or Foreign
	Funeral Director			1 M 2 F Yrs	Months Days Hours Min		1961 Ka	
			Usual Residence of Decedent			(J. 1. 0 0)	7.150	Thursd.
	ehow		10a. State 10b. County	10c. City, Town or	Roll's and		10	d. Inside City Limits 1 ☐ Yes 2 ☐ No
	88-1 c	Director	Maryiana My		DayTIMOIC	10.0	200	
	s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Menial Hygiene. Item 27 is marked other then: "naturel; or iteme 23s or 28s-f show other treumatic event, the Madical Examinar must be notified at	2	1325 E. BI	1dle St.	10f. Zip Code 21213	Tog. C	Citizen of What Country	ry r
	Jeath The 23	Funeral	11. Marital Status	12. Was Decedent Ever in U.S. 1	Was Decedent of Hispanic Origin? (S     If Yes, specify Cuban, Mexican, Puer	pecify Yes or No-	14. Race - America	
ယ္	after o	Fur	1 Never Married 2 Married	1 Yes 2 TNo		to Hican, etc.)	Black, White, e	tc.
5-0036	hours after turel', or its al Examina	d by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	1 ☐ Yes 2 ☐ No Specify:		Specify: Blac	K
5	natu	Completed	15. Decedent's E (Specify only highest g	rade completed) (G	ecedent's Usual Occupation live kind of work done during most of wo e. DO NOT use retired)	rking 16b.	Kind of Business/Indu	ustry
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<u>a</u> n	Aental Aental rked tic ev	To B	Horace Mer	rick	Joann	e Hart		
Maryland	2 should be filed within and Mental Hygiene. Ie marked other then eumatic event, the Me		19a. Informant's Name/Relationship	(Type, Print) 19b. M	ailing Address (Street and Number or R	ural Bute Number, City	or Town, State, Zip (	Code) 21214
	of Health litem 27 other tre		Joanne Jordan	-Mother 290	4 E. Northern	far Kway	Bautimar	e Maryone
Baltimore,	e ° = 5		20a. Method of Disposition  1  Burial 2  Cremation 3 i	ramatani i	sposition (Name of crematory or other place)	78/1/2 Ca	Location - City or Tow	vn, State
Ë	Pa Int:		4 Donation 5 Other (Spec		remajory	The Ca	HUNSUITE,	Par yigha
Baj	permit. Depertrimports Imports eny inju	ij	21. Signature of Funeral Service Lice	Harker	22. Name and Address of Facility	A Funer	ral Home	T.H. 2/204
			23a. Part1. Enter the disease, or cor	mplications that caused the death. Do not	enter the mode of dying, such as cardia	c or respiratory arrest,		Approximate
	Disconinina		shock, or heart failure. List onf Immediate Cause (Final			~		Interval Between Onset and Death
1	Physician /Medical		disease or condition resulting in death)	a. Sepsis  Due to (or as a consequence of):		-/ $/$		2 weeks
	Examiner			. Chemical pe	ritonitis	////		2 weeks
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	and I-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Leakage from Gas	crostomy site	MEDICA	LEXAMI	
8760,	cien cien buria	al E		Due to (or as a consequence of):		ON APPROVED O		
687	ate the	edical		d	CERTIL	ON APPROVED 8 POICA		
Box (	eath certific ettending p I for use as	J/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnancy	_		23d. Date of deliver	y
	death certific ie ettending p ad for use as	Icla	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live birth 2 Fetal death 4 Pregnant at time of death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		Month E	Day Year
P.0	by the	Physician/M	9 Unknown	9□ Unknown				
	Se De		Part II. Other significant conditions	contributing to death but not resulting in th			o use contribute to the	e cause of death?
ord	w requires been sign should be	ted	CJEFC Tronfal	lobe encephalo	malacea			
of Vital Records,	e law	Completed by		ral collection		24a. Was an autopsy performed?	24b. Were autop: prior to com death?	sy findings available ipletion of cause of
alF	Page T			Status-post fall wi		1 ☐ Yes 21Q		ZÜNG
Κ	5 8 6	o Be	25. Was case referred to medical examiner?	Hospital: 1 Impatient 2 ER/Outpa	Other	ath (Check only one) Home 5 \_ Residence	6 Other (Specify	
		n: To	27. Manner of Death	28a. Date of Injury 28b. Tim	e of 28c. Injury at	28d. Describe how inj		
ivision	Attending I r death. ector: After by the funer	atlo	1 Pending 2 Accident investigati	on <b>June, 2006</b> Unkn	OWN M 1 Yes 2 XNo	Subject fe	<u> </u>	
<u>₹</u>	or Attende siter de Directo in by the	Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine		, street, factory, office	- City or Town Sta	and Number or Rural	Route Number,
-Ω	urs ef	Cel		Hospital		Baltimore,	Mb Street	
	To the Hospital or Attendi within 24 hours efter death. To the Funeral Director: A completely filled in by the fu	edical		Physicien: To the best of my knowledge, d aminer: On the basis of examination and/o and manner stated.				
	To the within 2 To the comple	Me	29b. Signature and title of certifier		29c. License number	29d. D	Date signed (Month, D	Pay, Year)
			> Xlord to	tel MD	RESOOD	SEI	PTEMPE	2 . 22 . 200
	21		30. Name and address of person wh	o completed cause of death (Item 23a) (Ty			·UIDER	2,22,2006
_	~		SEJAL PATEL		ANOVER STREE	T, BALTI	MORE,	mD 2122
Ŋ.	Sta		31. Date filed (Month, Day, Year) NOV 0 2 2006	32. Registrar's Signature	£ 0		/	
	Regist	al	140 1 0 % 2000	FREE STATE STATE				

State of Maryland / Department of Health and Mental Hygien Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** HARPER **JEROME** CARLTON 13 2006 4:45p 8 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore Examiner Rosedale Franklin Square Hospital 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 239-60-1723 1 XM 2 ☐ F Yrs. 65 Director Md. 2-23-1941 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r then "naturel", or Iteme 23a or 28a-f ehow the Medical Examiner must be notified at Baltimore 1 Yes 2 □ No NA Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 5635 Utrecht Road 21206 USA Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No ģ Specify: Black 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) M.T.A. Bus Driver 12th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Hazel Lee Harper Unkn 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5635 Utrecht Road, Baltimore, Md. Wife Barbara Haper 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition Date permit. Pages 1
Department of Hu
Important: If iten
eny Injury or oth 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Owings Mills, Md. Garrison Forest Vet. 8-21-06 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F.H. East 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 1101 E. North Ave., Baltimore, Md 21202 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ASPHYXIA Physician MINUTES /Medical Due to (or as a consequence of): Examiner MINUTES ASPIRATION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner CERTIFICATION APPROVED BY MEDICAL EXAMINER physicien and s the burial-transit ACCIDENT VORES CEREBROVASCULAR Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical attending pt for use as t IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy in the past 12 months? Month 5 Other (specify) signed by the a d be detached f 1 ☐ Yes 2 ☐ No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Fibr, Ughon 3 Probably 4 ☐Unknown 1 TYes 2 No this certificete hes been si ral director, page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1 Yes 2 No 1 Yes the Hospital or Attending Physicien: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☑ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1ÆYes 2□ No 28a. Oate of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours To the Funeral Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 140480 DeTOSER 30 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ROAD FERNANDO FERRO MO MARYLAND 31. Date filed (Month, Day, Year) 32. Registrar's Signature State NOV 0 1 2006

Registrar

Courtes

State of Maryland / Department of Health and Mental Hygien 2 0 6 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 25 2006 9:25 A.M **Physician** Mark Steven Hewitt October /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Washington Med Ctr Glen Burnie Anne Arundel If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. 100 124. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 M 2 □ F 1957 213 80 4951 Maryland Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or Iteme 23a or 28a-f ehow or other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Director Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8544 Neptune Drive 21122 U.S.A. Funeral filed within 72 hours after death 14. Race - American Indian, Black, White, etc. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Be Completed by 3 Widowed 4 Divorced White "neturel", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Truck Driver Trucking 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) and Mental h Pages 1 and 2 should be 2 Robert J. Hewitt Gloria J. Maatta 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If Item 27 is eny Injury or other trau once. Joseph Pierce - brother 8544 Neptune Dr. Pasadena, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Bayview Crematory 10/27/06 Baltimore, MD 21. Signature of Euneral Septice Licensee 22. Name and Address of Facility GJ Gonce Funeral Home, 169 Riviera Dr. Pasadena, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or Meart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner 5-cus fally is conditional if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner burial-transit Hospital or Attending Physicien: The law requires thet the death certificate be executed ettending physicien and for use as the burial-tran resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4 Pregnant at time of death 5 Other (specify) ed by the e 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ page 2 should be 2**X** No 1 Tyes 3 Probably 4 □Unknown Be Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? rmed? 200 No 2□ No 1 🗌 Yes 1 Tyes : After this certifice funeral director, I 25. Was case referred to medical examiner? 26. Place of Death | Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification; To 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours efter death. To the Funerel Director: A investigation the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) the e 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) M ss of person who completed cause of death (Item 23a) (Type, Print) 32. Registrar's Signature State Registrar

06-08106 Arnilo Handy

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar Reg. No Decedent's Name (First, Middle,Last) Physician/ 2. Date of Death Month Day October 28, 2006 Medical Examiner Arnilo 0130 hrs Handy 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Johns Hopkins Hospital **Baltimore City** NA 5. Social Security Number Age (In yrs. last birthday If Under 1 Year | If Under 24Hrs **Funeral** Date of Birth (MM/DD/YYYY 9. Birthplace (State or Foreign Months Davs Min Hours Director 217-84-5120 1X M 2 Yrs 2-05-1976 Md. Usual Residence of Decedent 10a. State 10b. County any 10c. City. Town or Location 10d. Inside City Limits Md. NA 28a-f show Baltimore 1 X Yes 2 notified at once Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2746 Tivoly Avenue 21218 USA or items 23a Funeral 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian, Black, or other traumatic event, the Medical Examiner must be 72 hours after death Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 X Never Married 2 Married 2 X No Yes f Yes, Give Year 4 Divorced 1 Yes 2X No specify permit Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene Important: If item 27 is marked other than "natural", Specify. Black ð 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 12th grade Lab. Tech. Ceratech Inc. 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Henry Oliver Be Veronica Handy ٩ 19a. Informant's Name/Relationship (Type, Print ) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Veronica Handy Mother 1623 Cliftview Avenue, Baltimore, Md. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State X Burial 2 Cremation 3 Removal from State crematory or other place) King Mem. Pk. 11-3-06 Randallstown, Md. Donation 5 Other Specify Signature of Funeral Service Licensee 22. Name and Address of Facility 1101 E. North Ave., Baltimore, Md 21202 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear **Physician** Approximate Interval failure. List only one cause on each line Between Onset and /Medical a gunshot wound of chest Immediate Cause (Final disease Death Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) and Physician/Medical UNPENDED AMENDED certificate be Box 68760, attending physics or use as the b IF FEMALE 23c. If yes, outcome of pregnancy 23d Date of delivery 3b Was decedent pregnant in the 3 Ectopic pregnancy Fetal death Month Year past 12 months? Day Pregnant at time of death 5 Other (Specify) Yes 2 No 9 Unknown 9 gned by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Ö 23e Did tobacco use contribute to the cause of death? þ σ. 1 Yes 2 No 3 Probably 4 V Unknown Completed Division of Vital Records, peen 24a Was an 24b. Were autopsy findings available autopsy prior to completion of cause of certificate has performed? death? ✓ Yes 2 ✓ Yes 2 No 25. Was case referred to medical To the Hospital or Attending Physician: 26. Place of Death (Check only one) Be examiner? Other 4 this Inpatient 2 V ER/Outpatient 3 Nursing Home 5 Residence 6 ٩ 1 🗸 Yes No 28a. Date of Injury (Month, Day Year) Oct 28, 2006 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d Describe how injury occurred Certification: Natural 0000 hrs Subject shot 1 Yes 2 V No death 5 Pending Funeral Director: 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Could not be Suicide or Town, State) 2746 Tivoly Avenue, Baltimore, MD (Specify) Single Family 4 / Homicide 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started. Medical To the 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b Signature and title of certifier 29c License number 29d. Date signed (Month, Day, Year) O.C.M.E. October 28, 2006 Name and address of person who completed cause of death (Item 23a) Theodore M. King, Jr., MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

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Registrar

			For State Registrar		State of	Maryla		artmer ertificat				lental H	ygiene Reg. No	$\angle U$	06	34979
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	Funeral Director		213-10-3141		□м 2∏ F	93	Yrs.	Months	Days	Hours	Min.	10/07	ay, Year)		Coul	MD
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	p) / =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	,	Due to (o	r as a cons	equence of):									
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Division of Vital Records.	w requir been si should	Completed										24a. W	is an	24h 1	Were auto	psy findings available
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			For State Registrar	State of	Marylan		artment of F tificate of		d Mental Hyg	iene eg. N2 0 0 1	6 34980
		U.	Decedent's Name (First, Middle, La	st)					2. Date of Dear	th	3. Time of Death
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374	Funeral		Social Security Number     6. S	Sex 7 I□M 2 <b>X</b> F	. Age (In yrs.	*/	If Under 1 Year Months Days	If Under 24 h	Irs. 8. Date of Birth (Month, Day)	Year) 9.	Birthplace (State or Foreign Country)
4	Director		411-32-7541 Usual Residence of Decedent	-A-	90	Yrs.			February	24,1916	Kentucky
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	r 28a	Director	10e. Street and Number	gomery			10f. Zip Code	evy Cha		0g. Citizen of Wha	t Country?
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7	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show int, the Medical Examiner must be notified at	Completed by	15. Decedent's E (Specify only highest gra			(Give	lent's Usual Occup kind of work done DO NOT use retire:	during most of i	working	16b. Kind of Busin	ess/Industry
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altimore, Maryland 21215-0036	s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hygiene. The first and marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		19a. Informant's Name/Relationship (		100	19b. Mailin	g Address (Street	and Number or	Rural Route Number		
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ore.		H	20a. Method of Disposition			Place of Dispos	sition (Name of natory or other place	20)	Date	20c. Location - City	or Town, State
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	/Medical Examiner		resulting in death)		r as a conseq						Z WOOLD
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D.	death e atte	icia	in the past 12 months? 1 ☐ Yes 2 🂢 No	4□Pregnai	th 2□Feta nt at time of d		Ectopic pregnancy   Other <i>(specify)</i>	<u>'</u>		Month	Day Year
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ב	ding Phys J. After this funeral di	ion	27. Manner of Death  1 ☑ Natural 5 ☐ Pending		Day Year)	28b. Time of Injury	28c. Injur Wor M 1 □		28d. Describe ho	w injury occurred	
<u>S</u>	death ctor: / the	icat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be		f injury - At ho	me farm stre	eet, factory, office	Yes 2∐No	29f Location (St	root and Number o	r Rural Route Number,
DIVISION	after Direction by	Certification:	4 ☐ Homicide determined	building	, etc. (Specif	y)	ot, lactory, othog		City or Town	, State)	nurai noute Number,
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	le Ho	Medical	(Check only 2 Medical Examone)	niner: On the bas and manne	is of examina	tion and/or inv	estigation, in my o	pinion, death o	ccurred at the time, d	ate and place, and	due to the cause(s)
	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the funer	Me	29b. Signature and title of certifier	` .			29c. Licens	e number	29	9d. Date signed (M	onth, Day, Year)
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	12	ļ	30. Name and address of person who	completed cause	of death (Item	1 23a) (Type, F	Print)			OCCODE	2000
	1		Mary D. Restifo,				o Avenue	#342 W	ashington,	D.C. 20	016
	Sta Registr	_	31. Date filed (Month, Day, Year)	67	gistrar's Signa	iture	( September 1)				

		gistrar dent's Name <i>(First, Mic</i>						3 3, 2			Date of Deat	th		3. 1	ime of Death
sician	Ma	ry L. Hu	ighes								Month 10	29			04:05 Å
ledical aminer		lity Name (If not institut		et and numb	oer)		4b. City,	Town, or	Location of	Death			County of De		21405_1
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eral ctor		3-01-4768	6. Sex 1 ☐ M	20 <b>X</b> F	. Age (In yrs. <b>92</b>	iast birthday) Yrs.	If Unde Months	r 1 Year Days	If Under 2 Hours	Min.	Date of Birth (Month, Day, )6-23-1	Year)	9. E	Birthplace ( Country)	State or Foreig
		Residence of Decedent			100 Ci	ty, Town or Lo	ontion							10d In	side City Limit
1 2	10a. S	ate 10b. Cour	ity											1	Tyes 2 XN
ectc	DO	reet and Number				<i>l</i> ashing		p Code			1	On Citi:	zen of What	Country?	
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e a		27 Hilltop	12	Was Deced	ent Ever in U	J.S. 13.1	Was Dece	dent of Hi	ispanic Orig	in? (Speci	fy Yes or No-		<b>SA</b> 14. Race - A	merican Inc	dian,
by Funeral Director	1 [	Never Married 2 M	arried	Armed Ford 1 Yes 2 If Yes, Give Year or Dat	<b>△</b> No	1	fYes, spe 1 ☐ Yes	crfy Cuba	n, Mexican, Specify:	Puerto Ri	can, etc.)		Black, W Specify: <b>B1</b>		
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2	E	anger Thom	oson						Sa1	lie (	)dom				
	19a. l	formant's Name/Relation	nship (Type,	Print)		19b. Mailir	ng Addres	s (Street a	and Numbe	r or Rural i	Route Number	, City or	r Town, State	e, Zip Code	a)
		net H. Robl	oins/Da	ughte					Terra		. Wash				
or other traumatic event, the waster teaming that the inclines and other traumatic event.  To Be Completed by Funeral Director		ethod of Disposition  XBurial 2 Crematic	n 3 ⊡Rem	oval from SI		Place of Dispo cemetery, crei	natory or	ime of other plac	e)	Da	(8)	20c. Lo	cation - City	or Town, S	itate
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an	Imme	eart1 Enter the disease hock, or heart failure. I diate Cause (Final	, or complicat ist only one o	ause on ea	used the dea ch line. <b>SiS</b>	th. Do not ent	er the mo	de of dyin	g, such as o	cardiac or	respiratory arr	est,		Inter	roximate val Between et and Death <b>hours</b>
al	result	e or condition ng in death)	a		ras a consec	quence of):								40	Hours
er	Sequ ir any	ntially list conditions,	b		grene	of rig	ht lo	ower	1eg					A	days
E	Cause	leading to immediate Enter Underlying (Disease or injury tiated events	1	Per	iphera	1 Vasc	ular	Dise	ase					10	days
Examiner	result	ng in death) Last	0.	Due to (o	ras a consec	quence of):									
dicai			d.	Chr	onic C	)bstruc	tive	Lung	Dise	ase				10	years
Completed by Physician/Me	IF FE 23b.	AALE: √as decedent pregnant the past 12 months? □ Yes 2∑No □ Unknown	23c.	1 Live bir	ome of pregn th 2 ∐ Feta ntat time of o	aldeath 3[	Ectopic p Other (s					2	23d. Date of Month	delivery Day	Year
l Ph	Part II	Other significant cond	titions contril	outing to dea	ith but not re:	sulting in the u	nderlying	cause give	en in Part I.		23e. Did tol	bacco u	ise contribut	e to the car	use of death?
D D		Congestive	Heart	Failu	re						1 □ Y	es 2	□No 3 <b>X</b>	Probably	4 Unknow
ete		Renal Failu	ire								24a. Was a	in in	24b. Were	autopsy fi	ndings availab
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Be		Yes XXNo	_	28a. Date of	Injury	28b. Time o		28c. Injun	y at		d. Describe h	-		рөспу)	
To Be	1	nner of Death	and in our	(Month	, Day Year)	Injury	м	Worl	k? Yes 2.⊟1	No					
To Be	1	Natural 5 ☐ Per	estigation			nome, farm, st	reet, facto	ry, office		28	of Location (S			r Rural Rou	te Number,
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Certification: To Be	1 27. M 1 2 3 4	Natural 5 Per invo	estigation uld not be ermined fying Physic	building	g, etc. (Speci best of my kn sis of examin	ify) lowledge, deat	h occurred				nd due to the c	ause(s)	and manne		cause(s)
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ted in by the funeral director.  Certification: To Be	1 27. M 1 1 2 3 3 4 29a.	Natural Accident Suicide Homicide  Sertifier Check only One	estigation uld not be emined  fying Physic cal Examiner	building	g, etc. (Special special owledge, deat ation and/or in	h occurred vestigatio	n, in my o	pinion, deat	h occurred	nd due to the c	ause(s) late and	and manner	due to the		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 29, 2006 4c. County of Death **Physician** 4a. Facility Name (If not institution, give street and number) /Medical **Examiner** 4b. City, Town, or Location of Death Union Memorial Hospital Himore Age (In yrs. last birthday) Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** 1 ☐ M 2 💢 F Months Days Hours 85 Director 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits notified at 1 Yes 2 No Director Baltimore MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or 1005 Abbatt C Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status - American Indian Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after 1 Department of Health and Mental Hygene. Important: If them 27 is marked other than "natural," or ite any Injury or other traumatic event, the Medical Examines 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: Black
16b. Kind of Business/Industry 3 Widowed 4 ☐ Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Cashier 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Charles Wiggins
19a. Informant's Name/Relationship (Type, Print) Simmons Jueen 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jacqueline Blue Grand Daughter 20a. Method of Disposition 4401 Penhorst Ave. Baltimore 20b. Place of Disposition (Name of cemetery, crematory or other place) Nation | 2 □ Cremation | 3 □ Removal from State +45 11. 3.2006 Ballimore, mp 22. Name and Address of Facility Voughr, C. Greene June of Scruice 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 8728 libery Rd 23a. Part 1. Eater the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Roudalls taun MD 21133 Immediate Cause (Final disease or condition resulting in death) **Physician** Jepsis Syndrome ay /Medical Due to (or as a consequence of) Examiner oronary Sequentially list conditions, ir any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) Box 68760. Stroke Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 5 Other (specify) P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ binknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Medical Certification: Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HOSKIN MD MION 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar NOV 0 3 2006

			1 - For Stete Registrar Amend #10g F	State of Ma er FH C861 1	iryland 1/03/0	d/Depa %J <b>i©e</b> ≀	artment rtificate	of H	ealth a Death	ind M	ental Hy	giene	00	6	34983
	Physici /Medio Examin	al	Decedent's Name (First, Middle, La:     SEFIK     4a. Facility Name (If not institution, give			JUG		own, or	Location o	f Death	2. Date of De Month 10	16		rear 06	3. Time of Death 1:08 Mpl
	Funeral Director	CI	210-01-1991			1 Sys	If Under 1		timo: If Under 2 Hours		8. Date of Bin (Month, Da 07			9. Birthp	olace (State or Foreign ntry) Zegovina
	ne Maryland 8e-f show Aiffed at	ctor	Usual Residence of Decedent  10a. State 10b. County  MD NA		•	Town or Lo								1	0d. Inside City Limits 1 X Yes 2 □ No
	with the	I Dire	10e. Street and Number 102 North Marl	vn Ave			10f. Zip (		1227			Herz	SOVY	at Cour	itry?
36	be filed within 72 hours after death with the Maryland tal Hygiene. d other then "neturel", or tiems 23a or 28e-f show event, the Medical Examiner must be inclified at	d by Funeral Director	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 MN If Yes, Give Year or Dates:		1	Was Decede 1 Yes, speci 1 Yes 2	ent of His fy Cubar		in? (Spe Puerto f	cify Yes or No Rican, etc.)			White,	an Indian, etc. ucasion
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	s 1 and 2 should if Health and Mer item 27 is marke other treumatic		19a. Informant's Name/Relationship (3)  Jasna Jugo-Wife								Route Numbe re, Ba				
Baltimore,	permit. Pages 1 and 2 Department of Health Importent: if item 27 eny Injury or other tra pnce.		20a. Method of Disposition  1 X Burial 2 Cremation 3   4 Donation 5 Other (Specify	Removal from State	СӨ	ace of Dispormetery, crem	sition (Name	e of er place	)	D	ate	20c. Lo	cation - C	ty or To	
Balt	permit. Departr Imports eny Inji		21. Signature of Funeral Service Licen	see K- Im	ر د ر	22 M 4	Name and	Address F/I	s of Facility H Wes	st Ave.	Balt	imo	<u>ر</u>	ма	21215
	Physician /Medical		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. Pheoc	hror	Do not ente	er the mode							ITG	Approximate Interval Between Onset and Death
ı	Examiner	-F	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a	i Sy	ystem	Orga	an E	ailu	ire					
8/60, A	certificate be executed ding physician and use as the burial-transit	icai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a	_										
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ds, P.O	law requires that the as been signed by th 2 should be detache	by	Part II. Other significant conditions of	ontributing to death bu	t not resul	Iting in the un	iderlying cau	use give	n in Part I.						e cause of death?
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Vital	Physicien: this certific ral director,	o Be (	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital:	205	R/Outpatient	2000	Otho	~		(Check only o	10)			
sion of	D je je	$\vdash$	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day		28b. Time of Injury		c. Injury Work	4   Nur	2	e 5 Resid				)
DIVISION	5 # # C	Certification:	3 Suicide 6 Could not be determined	building, etc.	(Specify)						City or Tow	n, State)			Route Number,
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	To t To t	Σ	29b. Signature and title of certifier				29c.	License P21	number		4		signed (i		0ay, Year)
	2		30. Name and address of person who of Dr. Anne E. F	rosch 22	S.	Green	e St			alti	more,				
	Sta Registr		31. Date filed (Month, Day, Year)	32 Registral	r's Signatu	170	All I								

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Physician Medical Examiner  Ph	ore,	of Hea		1 4		Place of Disposition (Name o cemetery, crematory or other	f place)	Date 20	c. Location - City or T	Fown, Slate
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29a. Certifier (Check only one)  29a. Certifier (Check only one)  29b. Signature and title of certifier  29b. Signature and title of certifier  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  State  31. Date filed (Month, Day, Year)  32. Registrar's Signature	ion	ath. r: Alte	atlor	1 Malural 5 ☐ Pending		Injury		200.00000000000000000000000000000000000	anjury cocurred	
29a. Certifier (Check only one)  29a. Certifier (Check only one)  29b. Signature and title of certifier  29b. Signature and title of certifier  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  State  31. Date filed (Month, Day, Year)  32. Registrar's Signature	ivis	or Atter fler de Directo in by th	rtffc	datamina	286. Place of Injury - At n	nome, farm, street, factory, off	ice	28f. Location (Stree City or Town, S	at and Number or Rur State)	al Route Number,
30. Nam- and address of person who completed cause of death (Item 23a) (Type, Print)  Julie RBrahmerMD 1650 Orleans Street Baltimore Haryland 21231  State  31. Date filed (Month, Day, Year)  32. Registrar's Signature		spital	O	29a. Certifier 1 Certifying P	hysician: To the best of my kno	owledge, death occurred at th	e time, date and place	and due to the caus	se(s) and manner as	stated
30. Nam- and address of person who completed cause of death (Item 23a) (Type, Print)  Julie RBrahmerMD 1650 Orleans Street Baltimore Haryland 21231  State  31. Date filed (Month, Day, Year)  32. Registrar's Signature		in 24 h in 24 h the Fu	edic	(Check only 2 Medical Exa	miner: On the basis of examina	ation and/or investigation, in n	ny opinion, death occu	rred at the time, date	and place, and due t	to the cause(s)
State of Bull mod Marin Bay, out		To I To I	Σ	29b. Signature and title of certifier	-R. //					
State of Bull mod Marin Bay, out	4	- 1		30. Name and address of person who	completed cause of death (Item	m 23a) (Type, Print)	003177	Ue	tober	30 2006
State of Bull mod Marin Bay, out	0			Julie RBra	nmerMD 1	650,0 deur	SStree	Balton	ore Horyle	und 2/23/
				E-14 3 1 2 1 2 1 2 1 2 1 2 1 2 1 2 1 2 1 2 1	32. Registrar's Sign	ature Andrews			/	

				ype or Print State of Man					-		_	-1
			For State Registrar	State of War		ertificate of		LITICA TVI		Reg. No	duus	34985
	Physicia		1. Decedent's Name (First, Middle, Last)		Tl-				2. Date of Dea Month	Da	y Year	3. Time of Death
	/Medic	al	Aubrey	in at any number	Jack	.SON 4b. City, Town, o	y Location o	f Doath	october		. County of Death	12.54 PM
F.	Examin	er	4a. Facility Name (If not institution, give st Good Samaritan	Hespi	tal		imu			40	NA	
	Funeral Director		224-34-7037	7. Age (i	n yrs. last birthday 75	If Under 1 Year   Months   Days	If Under a	Min.	8. Date of Birth (Month, Day 5-9-	193	9. Birti Con	nplace (State or Foreign untry) Va.
	Maryland -f ehow	tor	Usual Residence of Decedent  10a. State 10b. County  Md. NA	1	Oc. City, Town or L Bal	ocation timore						10d. Inside City Limits 1   Yes 2   No
	n with the	al Direc	10e. Street and Number 3502 Tivoly Aver	iue		10f. Zip Code 212]	.8			10g. Cit	tizen of What Co	untry?
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Department of Health and Mental Hyglene important: if Item 27 is marked other than "natural", or Items 23s or 28s-f show says highty or other traumatic event, the Micdical Examinal months and Item 2006.	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Deceden! Eve Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	er in U.S. 13.	. Was Decedent of I If Yes, specify Cub 1 ☐ Yes 2 【XNo		gin? (Spe , Puerto I	cify Yes or No- Rican, etc.)		14. Race - Amer Black, White Specify:	
21215-0036	thin 72 ho le. lan "natur Medical	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	ation completed) College (1-4or 5+)	(Giv life.	edent's Usual Occup e kind of work done DO NOT use retire	during most d)	t of workii	ng		(ind of Business/I	
	iled w Hygier ther th		11th grade  17. Father's Name (First, Middle, Last)		Ste	eel Worker	T	r's Name	(First, Middle,		thlehem	Steel
land	should be filed within 7 and Mental Hygiene. s marked other than "umatic event, the Med	To Be	Willie		Jackson			lean			Brigg	S
Maryland	12 shouh and Mand Mand Mand Mand Mand Mand Mand	-	19a. Informant's Name/Relationship (Type Christine Jackson			ling Address (Street 700 Merida				-		
Baltimore,	Pages 1 and lent of Heali nt: If Item 2 ry or other		20a. Method of Disposition  1 Surial 2 Cremation 3 Re 4 Donation 5 Other (Specify)		20b. Place of Disp cemetery, cre		ce)		ate	20c. L	ocation - City or i	
Balti	permit. Departm Importe eny inju		21. Signature of Funeral Service License	Wane		22. Name and Addre		LI	arch F. , Balti			21202
	Physician /Medical Examiner		23a. Part1. Enter the disease, or complice shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	e cause on each line.	diac	airhy			r respiratory ar	rest,		Approximate Interval Between Onset and Death
		iner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to for as a c	ons uence of							
68760,	tificate be executed g physiclen and as the burial-transit	icai Examiner	that initiated events cresulting in death) Last	Due to (or as a c	consequence of):							
P.O. Box 6	death cer e attendin d for use	Completed by Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of 1 Live birth 2 4 Pregnant at tin	Fetal death 3	□Ectopic pregnanc □ Other (specify) _	у				23d. Date of deli Month	very Day Year
	requires that the een signed by th nould be detache	y Pr	Part II. Other significant conditions con		1	underlying cause gi	ven in Part I.					the cause of death?
ord	w require been sig should b	ted t		docard	(15				1 🗆 Y	es 2	□No 3□Pr	obably 4 Donknown
Rec	elaw hasb je2st	mple	Septic shock						24a. Was autop perfo		24b. Were au prior to death?	topsy findings available completion of cause of
Ta			End Stage re 25. Was case referred to medical	nal di	sease		26 Place	of Death	1 ☐ Yes	2 🖭 No	1 ☐ Yes	2 1 No
Ξ	S S	To Be	examiner?	ospital:	2 ER/Outpatio	ent 3 DOA Ot	hor				6 ☐Other (Spec	cify)
Division of Vital Records,	ffer ffer		27. Manner of Death 1 Matural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day )	28b. Time 'ea <i>r</i> ) Injury	Wo	ryat rk? ]Yes 2 □		28d. Describe h	now inju	ry occurred	
Divis	To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc.	· At home, farm, s (Specify)	street, factory, office			28f. Location (5 City or Tox			ral Route Number,
	Hospite 24 hours Funere	Medicai C	29a. Certifier 1 Certifying Phys (Check only one)	ician: To the best of er: On the basis of e and manner state	kamination and/or i	ath occurred at the t investigation, in my	ime, date an opinion, dea	d place, a	and due to the o	cause(s date an	s) and manner as d place, and due	stated. to the cause(s)
	within : To the comple	Me	OOL Circulus and title of position			29c. Licen	se number				ate signed (Monti	
	4		JALL Khee	jee m	ochb	RI	ES (	0.0	0	10	31 2	006

Registrar
DHMH 17 Rev 1/2001

State

BALTIMORE M.D.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

I. MUKHERSEE 5GOI LOCHRAVEN BLD

31. Date filed (Month) (Pay Year) 3 2005 32. Registrar's Signature)

				Please T	ype or Prir	it in Bl	ack In	delib	le Ink.	Ensure A	All Copies	Are	Legible.		
			For		State of Ma	aryland	/ Depa	artme	nt of H	lealth and	Mental Hy	gien	2006	34	986
			1 - State Registrar				Cei	tifica	te of	Death		Reg. No	-000	O	500
				e (First, Middle, Last)							2. Date of De	aath			of Death
	Physici		Nancy	Knickman							OCTOB	FRDa	27200	4215	55 M
2	/Medic Examin			If not institution, give st	reet and number)			4b. Cit	y, Town, o	r Location of Dea		1	County of Dea	0 0	
		•	SAINT	ACTNES	HOSP	ITAL	_	B	ALT	IMORI	=		n/a		
	Funeral		5. Social Security N			(In yrs. las	st birthday)	If Und Month	er 1 Year Days	If Under 24 Hrs Hours Min	8. Date of Bir	th Vear		thplace (State	e or Foreign
	Director		212-36-7	575	M 2.180(F	68	Yrs.	WOUTE	Days	riogis iviii	8. Date of Bir (Month, Da 3/21	/38	Ma	ryland	
	D >		Usuel Residence of 10a. State	Decedent 10b, County		100 City	Town or Lo	antina						10d. Inside	Olb I I I i i i i i
	anyla ehov	2				Too. Only,								1	es 2 KNo
	Ne M	ecto	MD	Howard			Elli		Cit	У	·····	10 0			-20
	with t	ā	10e. Street and Nu					101. 2	ip Code			10g. Cii	izen of What Co	ountry?	
	within 72 hours after death with the Maryland ene. than "naturel", or iteme 23a or 28a-f ehow he Madical Examiner must be notified at	Funeral Director		rth Chathan		Tuna in 11 C	12.1	Mar Day		042	2		USA	-daga lagina	
	er de	nu	11. Marital Status	ied 2 Married	2. Was Decedent I Armed Forces?		13.	f Yes, sp	ecify Cuba	lispanic Origin? (S an, Mexican, Puei	specify Yes of No rto Rican, etc.)	)·	14. Race - Ame Black, Whi		
36	rs aft	by F	3 ₹ Widowed	_	1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:	10		1 🗆 Yes	2 No	Specify:			Specify:	White	
阜	ture	ed		15. Decedent's Educ			16a. Deced	dent's Us	ual Occup	ation		16b. K	ind of Business		
15	n n	Completed		cify only highest grade	completed)		(Give life. l	kind of w	rork done use retired	during most of wo	orking			,	
27	iene iene	E	Elementary/Second 12	ondary (0-12)	College (1-4or 5	+)		Cler	ical			Ba1	timore	County	r
ਰੂ	otho	Bec	17. Father's Name	(First, Middle, Last)						18. Mother's Na	me (First, Middle	, Maiden	Sumame)		
<u>ਛ</u>	fenta fenta rked rked	To B	Joseph (	Centineo						Jose	phine Ca	mmar	ata		
ary	shot man	•	19a. Informant's N	ame/Relationship (Typ	e, Print)		19b. Mailir	ng Addre	ss (Street	and Number or R	ural Route Numb	er, City o	or Town, State, .	Zip Code)	
Σ	alth alth 27 is		Michele	Stedding /	Daughter	. []	5924	Johr	nyca	ke Road	Baltimor	e, N	laryland	1 21207	7
e e	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "naturel; or iteme 23a or 28a-f ehow any filury or other traumatic event, the Madical Examiner must be notified as once.		20a. Method of Dis			20b. Pla	ce of Dispo	sition (N	ame of other place	ое)	Date	20c. L	ocation - City or	Town, State	
Baltimore, Maryland 21215-0036	Page net contract int: If			☐ Cremation 3 ☐ Re 5 ☐ Other (Specify)	moval from State		imore	-	•	· 1	2/06	Ba1	timore,	Mary]	land
a E	mit. partn ports y inju		21. Signature of Fu	ineral Service Lipense	0	1	22	. Name	and Addre	ss of Facility L	oudon Pa	rk I	uneral	Home	
m	88 = 8		Cu	iere V	Cart	5	1 3	620	Wilk	ens Ave.	Baltimo	re,	Md. 212	229	
			23a. Part1. Enter t	he disease, or complic art failure. List only one	ations that caused	the deady.	Do not ent	er the mo	ode of dyin	ng, such as cardia	c or respiratory a	rrest,		Approxim Interval B	
	Physician		Immediate Cause disease or condition	(Final	RF5P1	RAT	DRY	F	11/1	18/=				Onser an	
	/Medical		resulting in death)	a.	Due to (or as	a conseque	nce of):	/_	1160	116				1011	<u> </u>
	Examiner				META	STA	TIC	CA	NC	ER				2 Wet	2K5
		De	Sequentially list co if any, leading to in cause. Enter Unde Cause (Diseese or	nmediate	Due to (or as	a conseque	nce of):								
	cute	Examiner	that initiated events	5 C.											
60,	be executed sician and burial-transit		resulting in death)	Last	Due to (or as	a conseque	nce of):								
6876	ate b hysic the bi	lical		d.											
9	death certificate b e attending physic od for use as the b	by Physician/Medica	JF FEMALE:												
Вох	ath co	an/	23b. Was deceden in the past 12	it pregnant	c. If yes, outcome 1 ☐ Live birth	2 Fetal d	eath 3		pregnancy	,			23d. Date of de Month	livery Day	Year
0	the de y the a sched f	Sic	1 ☐ Yes 2 J 9 ☐ Unknown	No	4□Pregnant at 9□Unknown	time of dea	th 5∟	Other (	specify)				141011111	24,	7.54
<u>o</u> .	that the de ed by the detached	Ph		ficant conditions cont	ributing to death h	it not result	ing in the w	nderhina	cauco an	on in Part I	23e Did i	obacco	use contribute to	o the cause o	f death?
S	8 LB 6		Tarrin out organi		induiting to doubting	20110110341	ing in the di	loonying	Cause giv	on arranti.		Yes 2	_		Unknown
9	w require been si should t	Completed									1			Tobacity 4	1011KHOWH
ec	hast je 2 s	jdu									24a. Was	psy	24b. Were at	utopsy finding completion of	s available cause of
=		S									1 Yes	rmed?	death?	2 □ No	
ij	Physicien: Th this certificate ral director, pag	Be	25. Was case refer examiner?						100		ath Check only	one)			
<u>5</u>	hysi this c	၉	1 ☐ Yes 2.2X	INO	spital: 1 Inpatie		R/Outpatien			4   Nursing i	Home 5 Resi			icify)	
Ē	ing F	i o	27. Manner of Deat 1 Natural	th 5 Pending	28a. Date of Injur (Month, Da)	Year) 2	8b. Time of Injury		28c. Injur Wor	k?	28d. Describe	how inju	ry occurred		
Sic	Attending r death. ector; After by the fune	cat	2 ☐ Accident 3 ☐ Suicide	investigation 6 ☐ Could not be				М		Yes 2 □No	0.71				
Division of Vital Records,	or Al	Certification:	4 Homicide	determined	28e. Place of Inju- building, etc	. (Specify)	e, tarm, str	eet, facto	ry, office		28f. Location (		nd Number or Ri n)	urai Route Nu	imber,
	To the Hospital or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.		29a Codifica	15 Continue Dh	cient To the best	of mu beaut	odae deed		d at *5- *	no data and -1	o and the time				
	Hospital	edical	29a. Certifier (Check only one)	1⊠ Certifying Physi 2  Medical Examin	er: On the basis of and manner sta	examinatio	n and/or in	vestigation	oral the tin	pinion, death occ	e, and due to the urred at the time,	date and	and manner as d place, and due	s stated. e to the cause	ı(s)
	To the within 2 To the complet	Mec	29b. Signature and	I title of certifier	and manner Sta			2	9c. Licens	e number		29d. Da	te signed (Mont	h. Dav. Year	
	or with Connection		Ann	ONO KOLA	ton M	1					) 6				
7	[		<b>₩</b> /Uα/	enu rueva	וו טושו	10.	20\ (T:	Priot)	17 X	1060	′ (	101	UBEI	1000	000
1	+		BOTEN	ress of person who con	TORY 4	TA A	-III E	5 H	050	ITAL. D	ALTIMO	2= 9	00 40 at	ON AUG	7
	Sta	te	31. Date filed (Mon	oth, Day, Year)	32. Registra	ar's Signatu	re IV C	- 11	V )	066C ITAL B	11-(1110)	10 11	ov Jeur	ON /TUE	-
	Registr	_		NOV 0 3 20	ns Read	20 0 1	M. A	Contract .	America .						

State of Maryland / Department of Health and Mental Hygien

34987

		•	State Registrar			Ce	rtificate of	f Death		Reg. N	io.	) ()	U = 7	10
3/5	Ag.		1. Decedent's Name (First, Middle, L	ast)		_			2. Date of D				3. Time o	f Death
	Physici		Robert Mentzer K	eefer Sr	•				NOVEMB		ay 20	906 006	2:30	P
	/Medic Examin	200	4a. Facility Name (If not institution, ga	ve street and num	nber)		4b. City, Town,	, or Location of De	eath	4	c. County	of Death	ז	
			Perry Point Vete	rans Hos	pital		Perryv	ille			Cec:	il		
at	Funeral		Social Security Number 6.		7. Age (In yrs.	last birthday	If Under 1 Year Months Day		Irs. 8 Date of B	irth	r)	9. Birth	nplace (State untry)	or Fore
190	Director		216-18-3466	1 <b>⊠</b> M 2∐F	84	Yrs.	Months Day	S Hours N	Dec.	24	1921	Mar	yland	
	D		Usual Residence of Decedent											
Σ	how how		10a. State 10b. County		10c. Cit	y, Town or L	ocation						10d. Inside C	
턵	Ma a-1.	cto	Maryland Cecil			North	east						1 🗌 Yes	, 2120
題	n the	lre	10e. Street and Number				10f. Zip Code	•		10g. C	Citizen of V	Vhat Co	untry?	
Ö	death with the Maryland oma 23a or 28a-1 show r must be colidied at	aic	38 Ironoak Ct.				219	01		US	A			
PHYSICIAN: KEEFER, ROBERT ryland 21215-0036	be filed within 72 hours after death with the Marylan tal Hygiene. d other then "naturel", or itema 23a or 28a-f show event, the Maritzal Exama or must be collitied at	Funeral Director	11. Marital Status	12. Was Dece Armed For	dent Ever in U	.S. 13.	Was Decedent of	f Hispanic Origin?	(Specify Yes or Nuerto Rican, etc.)	10-		e - Amer k, White	rican Indian,	
E 9	72 hours after naturel; or ite	Fu	1 Never Married 2 Married		2 🗌 No		1 ☐ Yes 2 ☑ N		, , ,		Specify		, 0.0.	
: KEEF! 5-0036	ours	d by	3 Widowed 4 Divorced	Year or Da	ites: WW]	I					Specify	Wh	ite	
<b>7.</b> ℃	72 h natu	Completed	15. Decedent's l (Specify only highest g			16a. Dece (Give	edent's Usual Occ e kind of work don	cupation ne during most of ired)	working	16b.	Kind of Bu	ısiness/l	ndustry	
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SG 7	filed w Hygier Ither th	ပ္ပ	12			Main	tenance :	Engineer					Leasin	g
SI	tal H d oth	Be	17. Father's Name (First, Middle, Las						Name (First, Middi			Θ)		
)HX		ို	Vance (unk) Keef	er					Edna Men					
<u> </u>	and and is m		19a. Informant's Name/Relationship	(Type, Print)		19b. Mail	ing Address (Stre	et and Number o	Rural Route Num	ber, City	or Town,	State, Z	(ip Code)	
	5 E Z E		Beatrice B. Keef	er/ Wife	8	38	Ironoak (	Court, N	ortheast	, Ma	rylar	nd 2	1901	
₹ S	es 1 ar of Hea fitem		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3	□ Bomoval from S	20b. F	Place of Disp cemetery, cre	osition (Name of ematory or other p	nlace)	Date	20c.	Location -	City or 7	Town, State	
KNOWN	Page nent nnt: if		4 Domation 5 Other (Spec		Moi	celand	Memoria	1 Pk   11	-6-06	Bal	timo:	ce,	Maryla	nd
E KNOWN Baltimore,	permit. Pages Department of Importent: if it any injury or o	1	21. Signature of Funeral Service Lic	thsee ~		1 3	2. Name and Add	tress of Facility	Home, P.	7\				
NAME Ba	P E E E		)tady 1	1	~ 5-4	/			d., Abin		Maı	rvla	nd 210	N9
NA I			23a. Farr . Enter the see se, or co	mplications that ca	aused the deat	th. Do not er	iter the mode of d	lying, such as car	diac or respiratory	arrest,	,	7	Approxima Interval Be	ite
	Discourse		Immediate Cause (Final	y one cause on ea								ļ	Onset and	Death
	Physician /Medical		disease or condition resulting in death)	a	OF as a consec		RUCTIVE	LUNG DIS	EASE				UNKNOW	Ν
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		9	Sequentially list conditions, if any, leading to immediate	b Due to (	RESPIR or as a consec		FAILURE						OTALCIACAA	TA
	De at its	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury											
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68760,	certificate be executed ding physicien and see as the burial-transit	/Medical		d		<del>-</del>								
×	ires that the death certificate be executed signed by the attending physicien and to be detached for use as the burial-transit		IF FEMALE:	23c. If ves. out	come of prean	ancv					23d. Dat	te of deli	ven/	
Bo	atter for u	Physician	23b. Was decedent pregnant in the past 12 months?		irth 2 ☐ Feta ant at time of c		□Ectopic pregnar □ Other (specify)				Moi		Day	Year
_•	the d	ysic	1 Yes 2 No	9□ Unkno		JOHIT 0	other (speeny)							
Division of Vital Records, P.O	that the detail	P.	Part fl. Other significant conditions	contributing to de	eath but not res	sulting in the	underiving cause	given in Part I.	23e. Dio	tobacco	o use conti	ribute to	the cause of	death?
ds,	sign and t	l by							12	7Yes	2 🗆 No	3 🗆 Pr	obably 4	Unknov
o.c.	w requir been si should	Completed				<del>-</del>			- /					
ec	as t e 2 s	npi							24a. We	ODSV	24b. \	Nere au	topsy findings completion of	cause c
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ita/	sien: ertific	Be	25. Was case referred to medical examiner?						Death (Check only	one)				
<u>_</u>	hysic nis co	2	1 ☐ Yes 2/2 No			ER/Outpatie	INT 3LI DUA		ig Home 5□Re	sidence	6 Oth	er (Spec	city)	
0	ng Pi		27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of (Mont	of Injury h, Day Year)	28b. Time Injury	of 28c. In	ljury at Vork?	28d. Describe	how in	fury occurr	ed		
.0	auth. pr: Al	atic	2 Accident investigat	ion				☐Yes 2☐No						
<u> </u>	ar de	tific	3 Suicide 6 Could not	20t. Flace	of Injury - At h	ome, farm, s	treet, factory, offic	ЭӨ	28f. Location City or T	(Street	and Numb	er or Ru	ral Route Nur	nber,
ō	et or A s after at Direct	Certification:	Table 1		· <b>g</b> , o (-p	,,,					,			
	hour hour uner								ace, and due to th					
	n 24 n 24 ne Fu	Medical	one)	ammar: On the ba	ner stated.	ation and/or i	nvestigation, in m	y opinion, death o	occurred at the time	e, date a	ind place, a	and due	to the cause(	S)
	To the Hospitel or Attending Physicien: The law requires that the death within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the atter completely filled in by the funeral director, page 2 should be detached for u	Σ	29b. Signature and title of certifier	11	7		29c. Lice	ense number		29d. [	Date signed	d (Monti	n, Day, Year)	
			1 Shalan	Motor 1	w		D203	890		NIO	ייי כואבוי	ר כ	2006	
	4		30. Name and address of person wh	o completed caus	e of death (fte	m 23a) (Type				WUV	EMBE	1	2006	
	0		Charles Hoesch, M.	D. VA Ma	brelvy	Heal+	h Caro S	watem.Pe	rry Poin	+ ,Mr	2190	12		
1	Sta	ate	31. Date filed (Month, Day, Year)	32. R	egistrar's Sign	ature		Y MANAGER						
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			0.100		The state of the s		1							

			Please	e Type or Prir							egible.	
		For		State of Ma	arylan		partment of I		lental Hyg	giene		
		State Registrar				C	ertificate of	Death		Reg. No. 2	2006	31,988
Physicia	an	Decedent's Nam	e (First, Middle, L	_ast)					2. Date of Dea Month	Day	Year	3. Time of Death
/Medic		MARY	If not institution a	ive street and number			KURL.		Octob	1	2000	
Examin	er	4.	-	ive street and number)	ikva	00	- 613	or Location of Death	ha	4c. Co	ounty of Death	
Funeral		5. Social Security N	1.0	Sex 7. Ag	-	last birthda	y) If Under 1 Year		8. Date of Birtl	h ,	9. Birth	N/A place (State or Foreign intry)
Director		219-16-	-2825	1□M 2□F	86	Yrs	Months Days	Hours Min.	(Month, Day 10/20/19		Cou	MD
pus		Usual Residence of 10a. State	Decedent 10b. County		10c Cit	y, Town or	Location			// N		10d. Inside City Limits
Aaryla F shored at	ō	MD	N/A	4		ALTIM						1 Y Yes 2 □ No
r 28a-f show	Director	10e. Street and Nu	mber				10f. Zip Code			10g. Citizer	n of What Cou	intry?
₹ 0.8		4005 F0	ORDS LAN	E			21:	215		U.S.A	1	•
ems 23a	Funeral	11. Marital Status		12. Was Decedent Armed Forces?	Ever in U.	S. 1	3. Was Decedent of I		ecity Yes or No-		Race - Ameri	
s after d	by Fu		ried 2 Married	1 ☐ Yes 2 ☑ I If Yes, Give X	No		1 ☐ Yes 2 ☑ No		riioari, oto.j		Black, White, pecify: いい	
72 hours natural", dical Exa		3 Widowed	4 ☐ Divorced  15. Decedent's	Year or Dates:		160 Do	Cedent's Usual Occur				MIII	
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should bund Ment marked umatic e	2	MAX 				KURL		GERTRU				GORDON
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ges 1 and 2 should be filed within to f Health and Mental Hygiene. If item 27 is marked other than or other traumatic event, the Me		PHILLIF 20a. Method of Dis	P MIZRACI	H/NEPHEW	20b. P	lace of Dis	5 LABYRIN	i (	BALTIMO		1D 2121 tion - City or T	
Pages nent of I int: If its		1 👿 Burial 2		☐Removal from State	0	emetery, c	rematory or other pla AEL CONG.	ce)			•	,
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permi Depa Impo any I		Mart	4 Leu				0000 001	SC	L LEVIN	ISON 8	BROS.	, INC.
8		23a. Part1. Enter t	the disease, or co	mplications that caused ly one cause on each li	the death	n. Do not	enter the mode of dyi	STERSTOWN ng, such as cardiac c	or respiratory ar	rest,	·VILLE,	MD Z1ZU8 Approximate Interval Between
Physician		Immediate Cause	(Final	, one sauce on saon in	ene	5						Onset and Death
/Medical		resulting in death)		Due to (or as	a c nseq	uence of):						raay
Examiner	L	Sequentially list co	onditions,	b								
ted sit	Examiner	Sequentially list co if any, leading to in cause. Enter Under Cause (Disease or	nmediate erlying injury	Due to (or as	a conseq	uence of):						
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h certificate be ex ending physician a use as the burial.				d								
tificat ig phy as the	Physician/Medical											
eath cer attendir for use	an/N	1F FEMALE: 23b. Was deceden		23c. If yes, outcome 1☐Live birth			3 □Ectopic pregnanc	ev.		23d	d. Date of deliv	
e death he atte	sici	in the past 12	□No	4□Pregnant a 9□Unknown			5 ☐ Other (specify) _				Month	Day Year
that the de ned by the a	Phy	9 Unknown		s contributing to death b	ut not rocu	ulting in the	underlying course gi	von in Dort I	22a Did to	hassa use		the cause of death?
signe	by	NSTE	C 13 - CA	1		-			1 🗆 Y		/	bably 4 Unknown
w requires to been signer should be	letec	1.00		ypertension		ype	a riproser	( to	24a. Was a			·
sician: The law requires that the death certificate be certificate has been signed by the attending physicia irector, page 2 should be detached for use as the bur	Completed by	COUNT	icile co	LLtrs					autop perfor	rmed2	prior to co	opsy findings available ompletion of cause of
	0	25. Was case refer	rred to medical					26. Place of Death		2 No	1 🗆 Yes	2 14 No
Attending Physiclan: r death. ector: After this certifica by the funeral director.	To B	examiner? 1 ☐ Yes 2 ☐		Hospital: 1 [[Hipatie	ent 2	ER/Outpa	tient 3 DOA Oth	ner: 4 Nursing Hor			Other (Speci	ifv)
ding Phys h. After this funeral dir		27. Manner of Dear	th 5 Pending	28a. Date of Inju (Month, Da	ry y Year)	28b. Time Injur			28d. Describe h			
tendil eath. tor: A	catic	2 Accident	investigat	on			M 1	Yes 2□No				
or At after d Direct in by	Certification:	4 Homicide	determine				street, factory, office		28f. Location (S City or Tow	Street and N vn, State)	lumber or Run	al Route Number,
e Hospital 24 hours a e Funeral C letely filled i		29a, Certifier	1 Certifying	Physiclan: To the best	of my kno	wledge, de	eath occurred at the t	ime, date and place	and due to the	rauso(s) an	d manner as	etatod
To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical	(Check only one)	2 ☐ Medical Ex	aminer: On the basis o and manner st	f examina	tion and/o	r investigation, in my	opinion, death occurr	red at the time,	date and pi	ace, and due t	to the cause(s)
To the within 2 To the comple	Me	29b. Signature and	Title of certifier	212 1	7		29c. Licens	se number			igned (Month,	
1		1/7-	the )	Elfred	M	D	RE	5-000		Oct	ober	31,2006
1		30. Name and add	ress of person wh	o completed cause of	eath (Item	23a) (Typ	oe, Print)		0 =			
		Vrit	ha GV	osh, My	7	Sin	ai Host	ertal o	of Bou	2trum	ore	
Sta Registr		31. Date filed (Mor	MOU o o	2006 32. Registr	ar s Signa	lure	South					
			MUA D 9	6000	100	6	1					

State of Maryland / Department of Health and Mental Hygiene) ( Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year **Physician** Sam B. Liberto November 2006 7:00 A. /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 338 Whitfield Road Catonsville Baltimore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Oct. 27, 1912 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 X M 2 □ F 94 Yrs. Director Italy 219-03-5251 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelth and Mental Hygiane. Importent: if Item 27 is marked other than "natural", or Items 23e or 28e-1 ehow any injury or other traumatic event, the Mandical Exemplant. 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County Baltimore Catonsville Maryland 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 338 Whitfield Road 21228 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerlo Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2K Married Specify: White 1 ☐ Yes 2X No Specify: Completed by 3 □ Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 College (1-4or 5+) Produce Manager Food 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Rosa D'Anna 2 Giuseppe Liberto 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rosemary Wright Niece 1433 Adams View Road; Catonsville, Maryland 21228 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation ☐ Other (Specify) New Cathedral Cem. 11/6/06 Baltimore, Maryland 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue; Catonsville, MD 21228 Funeral Servi & Licensee 23a. Part1. Enter the trisease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 0 Carrina Vrestate **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed as been signed by the attending physicien and 2 should be detached for use as the burial-transit Due to (or as a consequence of). P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 Other (specify) 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, autisterais 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 1 No 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an page After this certificate funeral director, pag 2 21to 1 ☐ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No Certification; To 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending To the Hospital or Attending within 24 hours after death.

To the Funeral Director: After completely filled in by the fun 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 烯 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Daiyby 0 , wo cause of death (Item 23a) (Type, Print) Bato, Md 21224 Bench St 3008 Robert LiBerts, MO 31. Date filed (Month, Day, Year) 32. Registrar's Signature State NOV 0 3 2006 Goeds Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien [9] 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 8-40AM ctob Leight Jr. William Edmund 1200/ /Medical Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Med Anni (entra) 15/ hos Russia If Under 24 Hrs. 8. Date of Birth (Month, Day, July 28 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral Months Days Hours 1 ☑ M 2 ☐ F MD 85 214-10-0221 Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 28a-f show other traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 No Director Pasadena Anne Arundel Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene. 21122 2162 Lake Drive USA Items 23a Completed by Funeral 12. Was Decedent Ever in U.S. Amed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. VYes 2 ☐ No Yes, Give 1 Never Married 2 Married White Baltimore, Maryland 21215-0036 õ 1 ☐ Yes 2 🛛 No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced Year or Dates: "natural", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) n and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Plumber Local Union 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Rouke William Ε. Leight Ruth 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health item 27 2162 Lake Drive, Pasadena, MD 21122 Mark Leight (son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Nov 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State = 5 permit. Page Department of Important: If any injury or once. Timonium, Maryland Dulaney Valley Cem. 2006 \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral S. Vice Lin nse 22. Name and Address of Facility Stallings Funeral Home, 3111 Mountain Road, Pasadena, MD 21122 hs that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, use on each line. Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or con shock, or heart ailure. List only or con ol catió Immediate Cause (Final Pnysician disease or condition resulting in death) /Medical Due to (or as a consequence of **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed and Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performe 1 ☐ Yes 25 No of Vital Hospital or Attending Physician: director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 14 Yes 2 No 1 Impatient 2 ER/Outpatient 3 DOA Medical Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending 1 Natural 1 🗌 Yes 2 No death. 2 Accident investigation within 24 hours after deat To the Funeral Director: 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \ Homicide certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature 2+1 30. Name and address of person who completed cause BUR 0 KUF

DHMH 17 Rev 1/2001

Registrar

NOV 0 3 2006

Division of Vital Records, P.O. Box 68760,

physicien and s the burial-transit The law requires that the death certificate be executed certificate After thi funeral of death. filled in by the fu To the Hospital within 24 hours a To the Funeral I

**Physician** 

/Medical

Examiner

**Funeral** 

Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heelth and Mental Hygiene. Int: If Item 27 is marked other then "natural", or itsms 23a or 28a-f show

Baltimore, Maryland 21215-0036

traumatic event, the Medical Examiner must be notified at

other

Department of the important: if its eny injury or of soce.

**Physician** 

/Medical

Examiner

Examiner

To Be Completed by Physician/Medical

Certification:

Medicai

Completed by Funeral Director

31. Date filed (Month, Day, Year) State NOV 0 2 2006 Registrar DHMH 17 Rev 1/2001

29b. Signature and title of certifier

30. Name and address of person who completed cause of death, (Item 23a) (Type, Print) 18/0 Prince Philip Drive. olney, MD 20832 32. Registrar's Signature

29c. License number

D005

29d. Date signed (Month, Day, Year)

			1- For Amend Item 29d per Dr., G861, 11-103/106dhb Registrar	34992
2.3	T 26		Decedent's Name (First, Middle, Last)     2. Date of Death	3. Time of Death
1	Physici Medi-			1700 M
1	Examir	ner		
R			5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthol	(0)-1-1-1-1-1
熨	Funeral Director		220-18-5802 12 80 Yrs.   Months   Days   Hours   Min.   APR 26, 1926   Simple Count   APR 26, 1926   Months   Days   Hours   Min.   APR 26, 1926   Months   Days   Months   Days   Hours   Min.   APR 26, 1926   Months   Days   Months   Months   Days   Month	ace (State or Foreign ry) NC
			Usual Residence of Decedent	IVC
	arylan show	-		d. Inside City Limits
	88-1	Director	MD N/A Baltimore	1 ☐ Yes 2 ☐ No X
	with the	Ö	10e. Street and Number 10f. Zip Code 10g. Citizen of What Count 21212 1TSA	ry?
	nit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland artment of Health and Mental Hygiene. ortant: if Item 27 is marked other than "natural", or Items 23a or 28a-f show injury or other traumatic event, in Mudical Examerat must be routilled at a.g	Funerai	4730 KIMDETIEISH RG 21212 USA  11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- 14. Race - America	ın İndian.
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Maryland	2 should be filed within and Mental Hygiene. Is marked other than aumatic event, the My		19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip or Town,	Code)
	is 1 and 2 of Health a ltem 27 to other train		Donald Matthews/Son 4736 Kimberleigh Rd Baltimore, MD 21212	
altimore,	of He		20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)  20c. Location - City or Townsteen Communication   20c. Location - City or Townsteen Communicatio	vn, State
Ë	permit. Page Department of Important: If any injury or once.		4 □ Donation 5 □ Other (Specify) Metro Crematory, Inc. 11/1/06 Political Metro Crematory	D
Bai	permit. Departr Importuent injudent		21. Signature of Funeral Septice Licensee C. Todd Dring Cremation Society of Maryland, Inc.	
	40200	Н	299 Frederick Rd Baltimore MD 21228	Approximate
-			shock, or heart failure. List only one cause on each line.	Interval Between
A E	Physician /Medical		disease or condition resulting in death)  Prohable Cardia Arrythmiz  Due to (or as a consequence of):	
4/3	Examiner		Muscardial Futarction	
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Box (	leath certific attending p I for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 23d. Date of deliver	
	death e atter	clai	in the past 12 months?  1	Day Year
P.0	that the de ted by the a detached t	hys	9 Unknown	
	9 5 e	by P	239. Did tobacco use continuity to teath out not resulting in the underlying cause given in Part I.	/
Records,	w requir been si should	ted	End-Stage Mancreatic Cancer 10 Yes 20 No 30 Proba	bly 4 ⊡triknown
ec	e law i has b	Completed	24a. Was an autopsy prior to com	sy findings available pletion of cause of
E	: The cate has, page	င်	performed? death?  1  Yes 2 No 1 Yes 2	2 ET No
Vital	Physician: Th this certificate ral director, pag	Be	examiner?	
of	Phys rat di	1: To	1 Enpatient 2 EMOutpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify)	
ion	nding Ph th. : After th s funeral	tio	27. Manner of Death 28a. Date of Injury 28b. Time of Injury at Work? 2 □ Accident investigation 28b. Time of Injury 48c. Injury at Work? 1 □ Yes 2 □ No	
Division	or Attendia after death. Director: At In by the fu	Certification;	3 Suicide 6 Could not be 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural City or Town, State)	Route Number,
Ö	itator rs afte at Dii	Cer	building, etc. (Specify)	
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	icai	29a. Certifier  Check only  Check only  Check only  Check only  Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated to the cause of	ted.
	To the within 2 To the complet	Medicai	one) and manner stated.  29b. Signature and title of certifier 29b. Signature and title of certifier 29b. Date signed #Month. @	ou Youri
	8 7 8 T		29b. Signature and title of certifier  29c. License number  29c. License number  29d. Date signed Month, Coctober 29,	0067
	12		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	
	15		Terrance Baker, MD 5601 Loch Raven Blvd, Baltimore, MD 3	21239
Sec. Sec.	Sta		NI IV IV VIIII SEE SEE SEE SEE SEE SEE	
53.	Registi	ar	LADA O O COO STATES NO. 180	

James Gano McClure, III

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

2006 34993

		I- For State Registrar		Cer	tificate of	Death				Reg. No	D.		
Physicia		Decedent's Name (First, Middle,L							2. Date of Month	Death Day	Year	3	. Time of Death
ledical Examin		James	Gano		re, III				Octob	er 21, 20	006		0350 hrs
		4a. Facility Name (if not institution, 110 Maple Avenue	give street and number	er)	4	b. City, Town Preston	, or Location	on of Dea	ith		c. County of I Caroline	Death	
Funeral	╗	Social Security Number     6.	Sex 7. /	Age (In yrs. Ia	ist birthday)	If Under 1		nder 24H	_	of Birth (MI	M/DD/YYYY)	9. Birth; Cour	place (State or Foreign
Director		036-52-1823	39	39 Yrs. Months Days Hours Min. Ja					1. 21, 1967			MD	
<u>*</u>	H	Usual Residence of Decedent  10a. State											
ow any	-		in a										1 Yes 2 X No
Aaryland 28a-f show 1 at once	흲	MD Caroli  10e. Street and Number	lile	rre	ston	10f. Zip Coo				10a C	itizen of What		
Mary r 28a	Director				300							Count	y:
ith the 23a o notifi		110 Map1e Avenue 21655  11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify								US Vr. No-	America	an Indian, Black,	
ath w items	Funeral	1 X Never Married 2 Marr	ed Armed Force	es?					to Rican, etc		White,		ar indian, black,
ier de		3 Widowed 4 Divorce	1 Yes	2 X No	1	Yes 2X	No spec	cify:			Specify:	Whi	te
urs af itnral	d b	15. Decedent's Education (Specific	or Dates: only highest grade of	completed)	16a. Decedent					16b	. Kind of Busir	ness/Ind	dustry
1215-0036 Id be filed within 72 hours after femal Hygiene. narked other than "natural", event, the Medical Examiner.	ompleted	Elementary/Secondary (0-12)	College (1-4	or 5+)	during mo	st of working	life. DO N	O i use r	etirea)		Retail		
o3(	ğ	12			Sales	Repres					Furnit		
filed v Hygi	O	17. Father's Name (First, Middle, La							me (First, Mid		en Surname)		
21215-0036 Uld be filed within 7 Mental Hygiene. marked other than	To Be	James G. McClu 19a. Informant's Name/Relationship		<del></del>	19b. Mailing	Address (S			ameron		City or Town,	State.	Zip Code)
MD 2 td 2 shou lith and N m 27 is n aumatic	۲	Joan C. Ray/Moti				,					RI 028		,
and 2 and 2 Health item 3	ł	20a. Method of Disposition			Place of Disposi	tion (Name o			Date		c. Location - C		own, State
imore, MD 21215-0036  Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.  Itant: If iten 27 is marked other than "natural", or items 23a or 28a-faht or other traumatie event, the Medral Examiner must be notified at once		1 Burial 2 XCremation		Me Me	rematory or oth tropoli	tan		10.	-25-06		lexand	ria	VΔ
	ł	4 Donation 5 Other Spec 21 Signature of Funeral Service		101	ematory 22.N	ame and Ado	ress of Fa				1 Home		, 111
Balt permit. Departi Import injury		Lennis (		ac							wich,		02818
Physician		23a. Part I. Enter the disease, or confailure. List only one cause or		ed the death.	Do not enter th	e mode of dy	ing, such a	as cardia	c or respirato	y arrest, s	hock, or heart		Approximate Interval Between Onset and
/Medical	ı	Immediate Cause (Final disease	<sub>a.</sub> Hanging										Death
•		or condition resulting in death)	Due to (or as a co	nsequence of	f):								•
	Je	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a co	nsequence of	f):								
A) = =	Examin	(Disease or injury that initiated events resulting in death) Last	Due to (or as a co	nsequence of	():								
ecuted ecuted - transit			d	<del></del>									
760, Grate be execut sphysician and the burial - tra	//Medical	UNPENDÉD	AMENDED							17	Old Date of d	a tip com c	
876 tificat ng phy	Σ	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, out			al death	3 Ect	topic preg	gnancy	ľ	23d. Date of de Month		ay Year
Box 68 c death certificate attending	Physician	past 12 months?  1 Yes 2 No 9 Unknown	4 Pregnant	t at time of de	o th	ner (Specify)							
Bo he dea the a	λy	lagrand lagrand	9 Olikilowi					n Boet I	230	Did tobace	co use contribu	ite to th	ne cause of death?
ires that the signed by t	ρ	Part II. Other significant conditio	is contributing to de	eath but not re	esulung in the u	ingerlying car	ise given i	iiraiti.	_	_		_	bly 4 Unknown
rds, l	Completed								24a.	Was an	24b. We	ere auto	opsy findings available
cords law requi	Jple									autopsy perform <u>ed</u>		or to co ath?	mpletion of cause of
Vital Rec ysician: The his certificate director, page	S									Yes 2 ✓	No 1	Yes	2 No
ician:	Be	25. Was case referred to medical examiner?	[Hospital: 1   Inn	ationt 2	ER/Outpatient		Other		ck only one)	5 Paci	idence 6 🗸	Other	Scene
Physical din	٦ ا	1 Yes 2 No	28a Date of	atient 2	28b. Time of Ir		Injury at V				njury occurred		
Division of Vital Records, talor Attending Physician: The law requires after death all Director: After this certificate has been set in by the funeral director, page 2 should 1	ion	1 Natural 5 Pendir	g FOUND: D	ay,Year)	FOUND:		Yes 2		Subject	hanged	self		
r Atte er dea irecto	ficat	2 Accident Investi	28e Place o		0300 hrs ome, farm, stree	et, factory, off	ice building	g, etc.				or Rura	al Route Number, City
Div	The state of the s									on, M	D		
Division of Vital Records, P.O. Box 68760, Guittin 10 the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Finneral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - trans	Accident  3 Noticide  4 Homicide  Could not be determined  (Specify)  Garage at residence  Oct 21, 2006  Osophic forms  Oct 21, 2006  Oct 21, 2006  Osophic forms  Oct 21, 2006  Osophic forms  Oct 21, 2006  Osophic forms  Oct 21, 2006  Oct 21, 2006  Osophic forms  Oct 21, 2006  O										d. cause(s)		
To the within To the comple	and manner stated.  29b. Signature and title of certifier  29d. Date signed (A												
	O.C.M.E. October 21, 2006												
7		30. Name and address of person w	ho completed cause	of death (Item	123a)								
	Mary G. Ripple MD. Deputy Chief Medical Examiner 111 Penn Street, Baltimore, MD 21201												
St Regist	ate	111111	32. Regis	trar's Signatu	ire	Crart s							

			1 - State Registrar	State of Maryla	nd / Depa	artment of F rtificate of	Death	Mental Hygiene		34994
	Physici		1. Decedent's Name (First, Middle, Last					2. Date of Death Month Da	y Year 2006	3. Time of Death
	/Medic Examir		4a. Facility Name (If not institution, give	street and number)	7		r Location of Deal	th 40	. County of Death	
	Funeral Director		Social Security Number 6. Se	x 7. Age (In yrs	s. last birthday)		If Under 24 Hrs Hours Min.	8. Date of Birth	Q Righ	place (State or Foreign ntry) yland
D			Usual Residence of Decedent  10a, State 10b, County	100.0	ity, Town or Lo	ncation	1 1			10d. Inside City Limits
death with the Maryland	-f sho	jo	Maryland Baltimo			ndalk				1 ☐ Yes 2 No
h the	r 28a	Director	10e. Street and Number			10f. Zip Code		10g. Ci	tizen of What Cou	ntry?
ath wit	23a c		7912 North Boundar	y Road		21	222		USA	
J <b>SO</b> Irs after dea	Department of Health and Mental Hygiene importent: if item 27 is marked other than "natural", or iteme 23a or 28a-f show my injury or other traumatic event, the Madigal Examinst must be notified at once.	by Funeral	11. Marital Status  1 □XNever Married 2 □ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in Armed Forces?  1  Yes 2 XNo If Yes, Give Year or Dates:	ľ	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 1 No	dispanic Origin? (S an, Mexican, Puer Specify:	Specify Yes or No- to Rican, etc.)	14. Race - Ameri Black, White, Specify: W	
D-UUSO 72 hours at	nature dical E	Completed	15. Decedent's Edi (Specify only highest grad	ıcation	16a. Dece	dent's Usual Occup kind of work done DO NOT use retired	nation during most of wo	orking 16b. K	(ind of Business/Ir	ndustry
within	then the Me	mpi	Elementary/Secondary (0-12) 12 years	College (1-4or 5+)	Mecha		d)		ody and 1	Fender
	other other	0	17. Father's Name (First, Middle, Last)		PIECITA	arric	18. Mother's Na	me (First, Middle, Maider		CHACL
ylan ould be	is marked of	To B	Lewis Mc Connell S	r.			Carolyn	A. Purcell		
Viar 12 sh	h and 7 is m traum		19a. Informant's Name/Relationship (T					ural Route Number, City		
<b>e</b> -	Healt tem 2		Lewis Mc Connell J  20a. Method of Disposition		Place of Dispo	sition (Name of	0-4	oad, Dundal Ober 200. L	ocation - City or T	
mor Pages	nt: if i		1 Burial 2 TCremation 3 III 4 Donation 5 Other (Specify,	Removal from State Ba	cemetery, crei Lyview (	matory or other plac Crematory	,		timore C	ity, MD.
Dall.	Departm importe any inju once.		24. Signature of Theral Service Licent	20h	<u>දි</u>	2. Name and Addresonnelly F 110 Solle	uneral Hers Point	lome Of Dund Road, Dund		21222
			23a. Fart1. Enter the disease, or comp	lications that caused the deane cause on each line.						Approximate Interval Between
	ysician Medical		Immediate Cause (Final disease or condition resulting in death)	a SUPOT	C 51+	DUC				Onset and Death
	aminer	ı		Due to (or as a conse	equence of):	+				40445
, D		iner	Sequentially list conditions, if any, reading to miniculate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conse		-				
DE COURT	physicien and s the burial-transit	ai Examin	Cause (Disease or injury that initiated events resulting in death) Last							
_ =		ledicai		d.						
O. BOX	been signed by the attending should be detached for use a	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of preg 1 □ Live birth 2 □ Fe 4 □ Pregnant at time of 9 □ Unknown	□Ectopic pregnancy □ Other (specify)		23d. Date of deliv Month	ery Day Year		
s that	ned b	by Ph	Part II. Dther significant conditions co	ntributing to death but not re	sulting in the u	inderlying cause giv	en in Part I.	23e. Did tobacco	use contribute to	he cause of death?
ecords, P.O.	en sig ould b		METASTATIC	PANCASAT	بر د	ANCER		1 Tes 2	□No 3□Prol	bably 4 Unknown
VICAL MECOLOS,	5 0	Completed	Typenerus	mis				24a. Was an autopsy performed?	prior to co	opsy findings available ompletion of cause of
<b>VIC</b> icien:	sertific ector,	Be	25. Was case referred to medical examiner?	doesital:		0,5		ath (Check only one)		
Physi	ral dir	To.	1 ☐ Yes 2 No 27. Manner of Death	lospital: 1 Unpatient 2(	ER/Outpatier 28b. Time o		4 🗀 (Yursing r	Home 5 Residence		fy)
on guibr	th. : After e fune	ation	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury	Wor	k?` Yes 2 □No	Lou. Describe now inju	ry cocurred	
DIVISION ei or Attending	s after death. ii Director: After id in by the funer	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At building, etc. (Spec		reet, factory, office		28f. Location (Street ar City or Town, State		al Route Number,
ne Hospit	within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	edical (	29a. Certifier 1 Certifying Phy (Check only one)	sician: To the best of my kr iner: On the basis of examinand manner stated.	nowledge, deat nation and/or in	h occurred at the tir vestigation, in my o	ne, date and place pinion, death occ	e, and due to the cause(s urred at the time, date an	) and manner as s d place, and due t	stated. o the cause(s)
To t	To the	ž	29b. Signature and title of certifier			29c. Licens			te signed (Month,	
7				yaym		1)	369 to	+ 10	1261	2006
	1		30. Name and address of person who c		om 23a) (Type, (♂子7	Print)	= PATU	+ 10 EINT PARK	in m	Corumeia
6	Sta	ate	31. Date filed (Month, Day, Year)	32. Registrar's Sign		ASTR OF T			1	7. 7.

Please Type or Print in Black Indelible Ink
State of Marvland / Department of Health and Mental Hy

mistine Monne	•	1- For State Registrar		or Maryland		tificate of		ia ivien	itai Hygi		eg No 20	06	3499
Physicia Medical Exami		1. Decedent's Name (First Christine								Date of Deat Month October 27	Day Year		ime of Death 0225 hrs
		4a. Facility Name (if not i	institution, give	e street and number)		4	b. City, Town, o			october 2	4c. County of	Death	
Funeral	Щ	Baltimore Wash  5. Social Security Number			(In vrs. la	est birthday)	Glen Burni		er 24Hrs 8	Date of Burt	Anne Aru		ce (State or Foreign
Director		219-08-30	007 1	M 2 <b>V</b> F	Months David House Little						ı	Country	) MD
any	1	Usual Residence of Dece 10a. State 10b.	County		10c. City,	Town or Location	on					10d	. Inside City Limits
faryland 28a-f show Lat once.	ē		Anne A	runde1	Pa	asaden						1 [	Yes 2 No
th the Maryland 23a or 28a-f sho notified at once.	Director	10e. Street and Number 8008 Wood	holm	Circle			10f. Zip Code 2112	2		10	U.S.A.	-	
with t ms 23a be not		11 Marital Status		12. Was Decedent	Ever in U.S		Decedent of H	ispanic Orig			14. Race -	American I	ndian, Black,
MD 21215-0036 2 should be filed within 72 hours after death with the Maryland hand Mental Hygiene 27 is marked other than "natural", or items 23a or 28a-f shomatic event, the Medical Examiner must be notified at once	by Funeral	Never Married 2  Widowed 4		1 Yes 2  If Yes, Give Year or Dates:	No		es, specify Cuba			an, etc.)	White,	<sup>etc.</sup> Whit	e
hours a		15. Decedent's Education Elementary/Secondary		nly highest grade com			s Usual Occupa			done	16b. Kind of Busi	ness/Indus	try
5-0036 led within 72 hours after itygiene other than "natural" the Medical Examine	Completed	1 1	y (U-12)	College (1-4 or 5	)+)	Home	maker				Own F	lome	
21215-0036 uld be filed within 7 Mental Hygiene marked other than c event, the Medica		17. Father's Name (First,									laiden Surname)		
212 vuld be Mental marke c event	To Be	Edward Mo				19b. Mailing	Address (Stre				1a Smit		Code)
		Geraldine		h/Mothe		8008	Woodh	o1m	Circ	le, P	asadena	, ME	21122
nore, MD 2121 sages I and 2 should be fi nt of Health and Mental t: If item 27 is marked other traumatic event,		20a. Method of Disposition  1 Burial 2 Cr		Removal from Sta	te c	lace of Disposit rematory or oth	er place)			ate	20c Location - C	,	
Baltimore, permit Pages I as Department of He. Important: If ite	1	4 Donation 5 C		see	Bay	yview 22. Na	Cremat ame and Addres	ory s of Facility	11/01 G.J.	Gonc	Baltim e Funer	ore,	MD Iome, PA
		Mul.	Z-			16	9 Rivi	era	Drive	e, Pa	sadena,	MD	21122
Physician /Medical		23a Part I. Enter the dise failure. List only one	e cause on ea	ch line.  Cardiac arr			e mode of dying	i, such as c	ardiac or res	spiratory arre	st, shock, or hear		proximate Interval etween Onset and Death
Examiner		Immediate Cause (Final or condition resulting in c	death)	Due to (or as a conse	quence of	):						-	
-10	er	Sequentially list condition if any, leading to immedia		Dilated car  Due to (or as a conse			left ven	tricula	ar hype	rtrophy			
	Examine	cause. Enter Underlying (Disease or injury that in events resulting in death	itiated <sup>C.</sup> -	Due to (or as a conse	quence of	):						_	
760, icate be executed physician and the burial - transit	a Ex	-	d										
60, ate be ex ohysician te burial	ledic	X UNPENDED  IF FEMALE:	X	#1,2	3a-h,		perME, G8	61, 11,	/21/06 '	IT	Lee : - Trans		
x 6876 h certifical tending ph use as the	an/N	23b. Was decedent pregn past 12 months?	ant in the	23c. If yes, outcom		2 Feta	al death 3	Ectopic	c pregnancy		23d Date of de Month	Day	Year
Box 687 e death certific the attending p ed for use as th	Physician/	1 Yes 2 No 9	Unknown	4 Pregnant at 9 Unknown	ime or dea	5 Oth	er (Specify)				Sep 6, 2	006	
P.O. E	by Pr	Part II. Other significant			but not re	sulting in the ur	derlying cause	given in Pa	art I		pacco use contribu		
ords, P.C.	ted l	Cirrhosis	of live	<u> </u>						1 Yes			4 Unknown
S a la	Completed								<u> </u>	autops perforr	y prid med? dea	or to comple ath?	etion of cause of
tal Recting the crian: The certificate ector, page	Be Co	25. Was case referred to examiner?	_				26.Plac		(Check only	1 Yes 2 one)	No 1	Yes	2 No
of Viting Physic After this of Uneral dire	P		No H	ospital: 1 Inpatie		ER/Outpatient 28b. Time of In		Other4	Nursing Ho		Residence 6 ow injury occurred	Other:	
on of cending Phath	tion:	1 X Natural 5	Pending	(Month, Day, Ye	ear)	Zob. Time of m		Yes 2		. Describe III	ow injury occurred		
Divisior Spital or Attend hours after death meral Director:	Certification:	2 Accident 3 Suicide 6	Investigation Could not be	28e. Place of Inj	ury - At ho	me, farm, street	, factory, office I	building, etc	c. 28f.	Location (St	treet and Number	or Rural Ro	oute Number, City
Div Hospital or 24 hours afte Funeral Dir tely filled in		4 Homicide 29a. Certifier 1 Contin	determined	(Specify) an: To the best of my	languloda	o dooth coours	ad at the time d	lote and ale	an and due				
To the Ho within 24 l To the Fu	Medical			On the basis of exame and manner stated.									se(s)
F 3 F 5	X	29b. Signature and title o	of certifier	1 0000	7_		29c. Licens				29d Date signed		ay Year)
(半)		30 Name and address of	f person who	completed cause of de	ath (Item	23a)	O.C.	IV1. C.			October 27, :	2006	
		Carol Allan, MD	Assista	nt Medical Exam	,	111 Penn S	treet, Baltim	ore, MD	21201				
St Regist		31. Date filed (Month, Da	y, Year) 3 2006	407	s Signatur	e from	E)						

DHMH 17 Rev 1/2001

ORIGINAL

			1 - For State Registrar	State of M	aryland / Dep <i>Ce</i>	artment of F	lealth an Death		giene 006	34996		
- Constant	Physici		Decedent's Name (First, Middle, Last)     RALPH	BENNETT N	1CCALL		, , , , , , , , , , , , , , , , , , , ,	2. Date of De Month		3. Time of Death 1:06 A M		
	/Medio Examir		4a. Facility Name (If not institution, give s NATIONAL NAVAL M	street and number) EDICAL CE		4b. City, Town, o BETI	HESDA	eath	4c. County of De	eath		
	Funeral Director		5. Social Security Number 6. Sex 241 46 1777 1X	7. Ag		Hrs. 8. Date of Bir Min. (Month, Da May 26,	v. Year)	Sirthplace (State or Foreign Country) th Carolina				
	Maryland a-f ehow	ctor	10a. State 10b. County  Virginia Prince Wil	liam	10c. City, Town or L	ocation				10d. Inside City Limits		
	th with the 23a or 28	Funeral Director	10e. Street and Number 4430 Hendricks Dri	ive		10f. Zip Code 22193			10g. Citizen of What	. Citizen of What Country?		
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f ehow apprintly or other traumatic event. The Mudical Exartinar must be routiled at once.	þ	11. Marital Status  1 ☐ Never Married 2 ☑ Married  3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces? 1 Yes 2 If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☑ No		? (Specify Yes or No uerto Rican, etc.)	14. Race - Ar Black, WI Specify: W			
Maryland 21215-0036	i within 72 ho iene. r than "natur ire Mudical	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	cation a completed) College (1-4or 5	(Give	dent's Usual Occup kind of work done DO NOT use retired	during most of	working	16b. Kind of Busines U.S. Gove	,		
yland 2	buld be fited Mental Hyg arked other atic event.	To Be C	17. Father's Name (First, Middle, Last) Ralph McCall	· · · · · ·			18. Mother's	Name (First, Middle, i 11		Imicito		
, Mar	and 2 sho salth and n 27 Is ma		19a. Informant's Name/Relationship (Typ. Joan T. McCall	oe, Print)	4430	Hendricks	. Drive		er, City or Town, State			
Itimore,	Pages 1 ment of Hi ant: If itan ury or oth		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	20b. Place of Dispo cemetery, cres Quantico	Nat. Cem.	11,	Date /1/2006 7	20c. Location - City of	Virginia		
Balt	permit. Departimport eny inj		21. Signal of uneral Service Ligense	oll-	4	143 Dale	Blvd. I	Dale City.	e Funeral VA 22193	Home		
· 新	Physician /Medical		23a. Part1. Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	·STA	the death. Do not en	er the mode of dyin	ig, such as care	diac or respiratory ar	rest,	Approximate Interval Between Onset and Death		
o,	ate be executed thysician and hysician and ihe burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b. Due to (or as a consequence of).									
P.O. Box 68760	death certificate e attending phy: id for use as the	Physician/Medical	fF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c, ff yes, outcome 1 ∐Live birth 4 □ Pregnant at 9 □ Unknown	2 ☐ Fetal death 3 ☐	Ectopic pregnancy Other (specify)			23d. Date of d Month	elivery Day Year		
	law requires that the as been signed by th 2 should be detache	þ	Part II. Other significant conditions conf	tributing to death b	ut not resulting in the u	nderlying cause give	en in Part !.			to the cause of death?  Probably 4 (**)  Unknown		
Vital Records,	The ate h page	Completed		5.00 Sec. 1				24a. Was : autop perfor 1 \( \text{Yes} \)	sy prior to med? death?	autopsy findings available completion of cause of s 2 \( \text{No} \)		
Division of Vit	ding Phys h. After this funeral di	ation: To Be	25. Was case referred to medical examiner?  1  Yes 2 No  27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28c. Injury Work	er: 4 🗆 Nursin		ne) lence 6 Other (Sp low injury occurred	ecify)				
DIVIS	o afte	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injubulding, etc.	ury - At home, farm, str c. (Specify)	eet, factory, office		28f. Location (S City or Tow	itreet and Number or F n, State)	eet and Number or Rural Route Number, State)		
	the the	Medical	one)	icien: To the best of er: On the basis of and manner sta	of my knowledge, death examination and/or in- sted.	estigation, in my op	oinion, death o	ccurred at the time, o	date and place, and du	e to the cause(s)		
-	Too con	_	29b. Signature and title of certifier	W		Name of the last o	33383	(VA)	29d. Date signed (Mor	12006		
0			DRAKE H. TILLEY	LT MC	USN			L NAVAL ME A MD 20889		TER		
	Sta Registr		31. Date filed (Month, Day, Year) 3 20	32. Relistra	ar's Signature	Cont						

			For State Registrar		State of Ma	arylan			nt of H te of L		Mental I	Hygien Reg. N	200	5	34997
				e (First, Middle, Last)							2. Date o	f Death			3. Time of Death
	Physici /Medic		Dorothy	M. Marvel							OCTO	OBER	3/ 20	96 106	1:07 PM
	Examin		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death  4c. County of Death												
				ENS NUM							SKACE		HAR	FOR	2
	Funeral		5. Social Security N		7. Ag		last birthday): Yrs.	If Und Month:	er 1 Year S Days	If Under 24 H Hours M	rs. 8. Date of <i>Month</i>	f Birth Day, Yea	(r) 9.	Birthpla Countr ary I	ce (State or Foreign
	Director		215-07-1 Usual Residence of	11/		90	113.				0/1	2/10	P	aryı	.auu
	land ow		10a. State	10b. County		10c. Cit	y, Town or Lo	cation		· · · · · · · · · · · · · · · · · · ·				100	d. Inside City Limits
	Mary -feh	to	MD	Baltimo	re		Arb	utus	5						1 ☐ Yes 2 XNo
	r 28.	lrec	10e. Street and Nu			L		10f. Z	ip Code			10g. C	Citizen of Wha	it Countr	y?
	h with	DE	1101 Ci	rcle Drive					21227	7			USA		
	deat	by Funeral Director	11. Marital Status		12. Was Decedent Armed Forces?	Ever in U.	.S. 13.	Nas Dec			(Specify Yes o	r No-	14. Race -		
9	or its	/Fu		ied 2 Married	1 Yes 2				20 No	Specify:	ono i neari, etc.	1	Specify:	White, et	C.
8	within 72 hours after death with the Maryland ene. than "naturel", or iteme 23a or 28e-f ehow he Madical Examiner must be notified at		3.2 Widowed		Year or Dates:									Whi	
2	nat disa	Completed	(Spec	15. Decedent's Educ cify only highest grade	cation completed)		16a. Deced	kind of w	vork done d	luring most of v	vorking	16b.	Kind of Busin	ess/Indu	istry
7	withir ene. than	Ę.	Elementary/Seco	ondary (0-12)	College (1-4or :	5+)	life. DO NOTuse retired)  Receptionist			Optical					
9	filed Hygi Sther		17. Father's Name	(First, Middle, Last)	00		лес	ерс.	LOHIS		lame (First, Mi				
Maryland 21215-0036	2 should be f and Mental I Is marked of reumatic eve	To Be	Louis	McGinn						Flo	rence A	dams			
ary	shou nd M mar	-		ame/Relationship (Typ	ое, Print)		19b. Mailir	ng Addre	ss (Street a	and Number or	Rural Route N	ımber, City	or Town, Sta	te, Zip C	Code)
	nd 2 alth a 27 to		Mrs. Pat	ricia Soch	a/ Daugh	ter	1215 (	la 1 de	re11 (	Court S	outh B	elcan	m. Md.	210	017
ē,	of Health of Hem 27 I		20a. Method of Dis	•		20b. P	lace of Dispo	sition (N	ame of		Date		Location - Cit		
E	Peges nent of I ant: if Ite		1 ☐ Burial 2 4 ☐ Donation	☐ Cremation 3 ☐ Re 5 MOther (Sequitor)	emoval from State  mbment	1	-			ery   11	/4/06	Bal	ltimore	e, Mo	1.
Baltimore,	permit. Peges 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Health and Mental Hygiene. Important: if Item 27 is marked other than "naturel", or iteme 23a or 28e-f ehow entry or other treumatic event, the Madical Examinat must be notified at an ODCs.		21. Signature of Fu	uneral Service License	0	-	//				Loudon . Balti				
			23a Part1 Enter I	general or comple	cations that caused	t the death							, milys		Approximate
	Physician /Medical Examiner		shock, or hea Immediate Cause disease or condition resulting in death)	ne disease, or comple art failure. List only on (Final on a	Due to (or as	211	Can	CE							nterval Between Onset and Death
	Ladillillei	_	Sequentially list co	enditions, b	000/Aut but Warren's		Olecologic (Carlo								
	ed sit	Examiner	cause. Enter Under Cause (Disease or	erlying	Quaito (or se	a coneaq	seuce ori:								
	ificate be executed g physicien and as the burial-transit	xan	that initiated events resulting in death)	s 🔳 c	Due to (or as	a consequ	uence of):	-						-	
60	be e	E													
68760,	ficate p phy: is the	edical		0											_
Box	= 0,0	Ž.	IF FEMALE: 23b. Was deceden	at pregnant 23	3c. If yes, outcome								23d. Date o	f delivery	,
	0 0	Physician/M	in the past 12 1 ☐ Yes 27	months?	1 Live birth 4 Pregnant at			Dectopic (	pregnancy s <i>pecify)</i>				Month		ay Year
P.0.	by th	hys	9 Unknown		9□ Unknown										
Vital Records, F	The law requires that the death cer tie has been signed by the ettendir page 2 should be detached for use	Ď	Part II. Other signi	ficant conditions con	tributing to death b	ut not resi	ulting in the u	nderlying	cause give	n in Part I.		Oid tobacco	~/	te to the	cause of death?
20	w requir been si should I	lete	-								242 \	Vas an	24h Wer	e autone	sy findings available
Re	he iay e has ige 2	Completed									-   a	utopsy erformed?	pno dea	r to comp th?	oletion of cause of
a	in: Ti	ပို	25. Was case refer	rred to medical	-			11000		DE Bloss of F	1 TY		10	Yes }	X10
>	s cert direct	0 B	examiner?	/	ospital:	ent 2 🗆	ER/Outpatien	t 3 🗆 [	Othe		eath Check of Home 5 I	10	6 □Other /	Specific	
of	Attending Physician: r death. ector: After this certific by the funeral director.		27. Manner of leaf	th	28a. Date of Inju	ıry .	28b. Time of		28c. Injury	at			jury occurred	Specify)	
ion	ath. r: Aft	atlo	1	5 Pending investigation	(Month, Da	y rear)	Injury	М	Work	r ∕es 2∐No					
Division	5 E E	Certification;	3 Suicide 4 Homicide	6 Could not be determined	28e. Place of Inj building, et			eet, facto	ory, office			on (Street a Town, Sta		r Rural i	Route Number,
	the Hospitai hin 24 hours e the Funerai I npletely filled	Medical C	29a. Certifier (Check only one)	Certifying Phys	er: On the basis o	f examina	wledge, death	occurre estigation	d at the tim	e, date and pla pinion, death oc	ice, and due to curred at the ti	the cause( me, date a	(s) and manne	er as stat	led. he cause(s)
	To the within 2 To the complet	Mec	29b. Signature and	title of certifier	and manner st	atou.		2	9c. License	number		29d. D	ate signed (A	Aprith, De	ey, Year)
	F 3 F 8		) A	The	MIS				-		7	ł.		/	-
ľ			30 Name and add	ress of person who co	moleted cause of a	leath /Ito-	23a) /Tune	Print					11		
1	)		M. J	o khadh	av 31	9	, ,	24	Ave,	Have	erde C	Jelle,	, us 2	10	78
	Sta Registr		31. Date filed (Mor	nth, Day, Year)	32. Registr	ar's Signa	ture	E S	6.3						

MARVEL, DOROTHY

06-08262 Lucille Michaels

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

2006 34998

		1- For State Registrar	Certificate of Death Reg No 2000								
Physician/ 1 Decedent's Name (First, Middle,Last) edical Examiner LUCILLE						HAELS	2. Date of Dea Month Novembe	r 1, 2006 Year	3. Time of Death 1134 hrs		
A CONTRACTOR OF THE PARTY OF TH		4a. Facility Name (if not instituted Park Heights Ave. & \$				Town, or Location o	f Death	4c. County of Death Baltimore County			
Funeral Director	140	5 Social Security Number  537–24–7469  Usual Residence of Decedent	6. Sex 7. Ago	e (In yrs last bir	thday) If Un Mon Yrs	Birthplace (State or Foreign Country)					
vlaryland 28a-f show any <u>1 at once.</u>	tor	WA 10b County	NGS	10c City, Town	TLE				10d. Inside City Limits 1 X Yes 2 No		
ith the Maryland 23a or 28a-f sho notified at once.	Director	10e Street and Number 5113 SOUTH B	RIGHTON STRE	ET		9 Code		U.S.A.	Country?		
iter death wi ", or items er must be	by Funeral	3 X Widowed 4 Div	orced If Yes, Give Year	X No	If Yes, spec	dent of Hispanic Origorify Cuban, Mexican,  2 X No specify:	n? ( Specify Yes or No Puerto Rican, etc.)	o- 14. Race - A White, e Specify. W			
<b>036</b> ithin 72 hours at see.	ompleted b	15. Decedent's Education (Spe Elementary/Secondary (0-12) 12		5+)		al Occupation (Give k orking life DO NOT to 100TER		16b. Kind of Busin	BELL COMPANY		
D 21215-0036 should be filed within 7 should be filed within 7 in Mental Hygiene 7 is marked other than atic event, the Medica	Be C	17. Father's Name (First, Middle	3		ORNELL	REGI			ROMEY		
ore, MD 21 es I and 2 should I of Health and Mei If item 27 is mai	ը	19a Informant's Name/Relations  CHERYL DWORK		R  6	900 FIEL	DCREST RO	ber or Rural Route Nu AD - BALTI	MORE, MD	21215		
Baltimore, MD 21215-0036 ocrnit. Pages I and 2 should be filed within 77 Department of Health and Mental Hygene important: If item 27 is marked other than nijury or other traumatic event, the Medical		20a Method of Disposition  1 Burial 2 Cremation  4 Donation 5 Other S	n 3 Removal from Sta	20b. Place crema teCONGRE	of Disposition (Na tory or other plac GATTON A HIM	HAVATH 1	Date 1/03/2006	SEATTLE,	WA		
Baltimo permit Pages Department o important: injury or oth	0. 0	21. Signature of Funeral Service  OM  23a Part I Enter the disease, or failure. List only one cause	domplications that caused	the death. Do n	8900		TOWN ROAD	- PIKESVI	ROS., INC. LLE, MD 21208		
/Medical Examiner	8 1	Immediate Cause (Final disease or condition resulting in death)	N. A (Alice 1 - 1 - 1 - 1 - 1 - 1 - 1	equence of).					Between Onset and Death		
	miner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	b. Due to (or as a conse	quence of):			_				
ed nsit	events resulting in death) Last Due to (or as a consequence of):										
760, icate be executed physician and the burial - transit	n/Medical	UNPENDED X AMENDED #5,17, perINF, g861,11/13/06 TT  IF FEMALE: 23c If yes, outcome of pregnancy 23d Date of delivery									
<b>∞</b> ≒ ≅ s l	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1  Yes 2 ✓ No 9 Un	he 1 Live birth			a 3 Ectopic	pregnancy	23d Date of del Month	ivery Day Year		
P.O. es that the igned by	ρ	Part II. Other significant condit		but not resultin	ig in the underlyin	ng cause given in Par			e to the cause of death?  Probably 4 Unknown		
law has	ompleted								e autopsy findings available to completion of cause of th? Yes 2 No		
ital Recional Recional The Sectificate rector, page	BeC	25. Was case referred to medica examiner?				26.Place of Death (	Check only one)				
Vit hysic this o	To	1 Yes 2 No	Hospital: 1 Inpatie				Nursing Home 5	Residence 6	Other Scene		
ion of Vitending Phyteath	ertification:	27. Manner of Death  1 Natural 5 Pener 2 Accident Inve	28a Date of Inju (Month, Day You Nov 1, 2006 stigation	ry 28b. ear) 113	Time of Injury 3 hrs	28c. Injury at Work?	Passenger	how injury occurred of auto involved	l in collsion		
Division of Vital F To the Hospital or Attending Physiciau: within 24 hours after cleath To the Funeral Director: After this certifi completely filled in by the funeral director,	Certific	3 Suicide 6 Cou				y, office building, etc	or Town	State	r Rural Route Number, City Or., Pikesville <sup>*</sup> , MD		
To the Hos within 24 h To the Fur	Medical	(Oncorr of h)	hysician: To the best of my iminer: On the basis of exar and manner stated	-							
	Ř	29b Signature and title of certific	M. H		29	O.C.M.E.		29d Date signed  November 1,			
6	8 01		outy Chief Medical E	, ,	11 Penn Stre	eet, Baltimore, N	/ID 21201		200		
S Regis	tate	N 1 ( ) 1 ( ) 1 ( ) 1 ( ) 1 ( ) 2 ( ) 2 ( ) 2 ( ) 3 ( ) 3 ( ) 2 ( ) 3 (									

			1 - For Amend #!, perMD, G	State of Maryland 361,11/3/06 TT		rtment of F		Mental Hy	giene	006	34999		
186	. C 667 x		Decedent's Name (First, Middle, Last)					2. Date of Dea	ith		3. Time of Death		
er.	Physici /Medic		GARY T. MORRIS		rison			oCT 25			10:00AM M		
*	Examin	er	4a. Facility Name (If not institution, give s 616 Back River Nec	· ·		4b. City, Town, o Middle		ath		ounty of Death altimor	e		
4.	Funeral		Social Security Number 6. Sex	7. Age (In yrs. la	If Under 24 Hi		h Vear	9. Birth	place (State or Foreign ntry)				
3	Director		424-72-53/3	M 2□ F 55	Yrs.	Months Days	Tiours	Sept 9	1951		bama		
	land ow		Usual Residence of Decedent  10a. State 10b. County	10c. City,	Town or Loc	cation					10d. Inside City Limits		
	B-f Sh	tor	MD Baltimore	e Midd	le Riv	er					1 ☐ Yes 2X No		
	if the	Oire	10e. Street and Number			10f. Zip Code			10g. Citize	on of What Cou	ntry?		
	a 23a	rai	616 Back River Nec		10.11	21221			U.S.A		and trading		
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23s or 28s-1 show any injury or other traumatic event, Its Madical Examinations in collidations.	by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	If	Yes, specify Cuba	Ilspanic Origin / i an, Mexican, Pue Specify:	(Specify Yes or No- arto Rican, etc.)		Race - Ameri Black, White, Specify: W			
2-0	72 hc natur	Completed	15. Decedent's Edu (Specify only highest grade	cation a completed)	16a. Deced	ent's Usual Occup kind of work done OO NOT use retired	ation during most of w	orking	16b. Kind	d of Business/Ir	dustry		
121	within ene. than	mp	Elementary/Secondary (0-12) 12th grade	College (1-4or 5+) O years		:/Music M	-		Raf	Ligious			
	filled Hygid other	Be Co	17. Father's Name (First, Middle, Last)	o years	Lastor	/IIusic II		ame (First, Middle,					
<u>/lar</u>	uld be Menta arked stic ev	To B	John Morrison				Polly	Covington					
Maryland	2 sho and ls ma		19a. Informant's Name/Relationship (Ty					Rural Route Numbe					
	1 and Health em 27		Linda Morrison, wi			SACK KIVE sition (Name of natory or other place		Road, Mid		ation - City or T			
Baltimore,	Pages ent of nt: if it ry or c		1 Burial 2 □ Cremation 3 □R 4 □ Donation 5 □ Other (Specify)	emovar nom otate				20-06			Alabama		
alti	permit. F Departm Importar any injui		21. Signature of Funeral Service License		> 22.	11 Cemet	ss of Facility C	harles S					
8	88 5 8	11	The f	5		6224 Eas	tern Av	enue, Bal	timoı	ce, MD	21224		
			23a. Part1. Enter the disease, or complishock, or heart failure. List only or	cations that caused the death. use on each line.	Do not ente	er the mode of dyin	ig, such as cardi	ac or respiratory ar	rest,		Approximate Interval Between Onset and Death		
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	aclas	tous	1					2 years		
	Examiner		f .	Due to (or as a consequence of): b.									
	P ≅	ner	if any, leading to immediate cause. Enter Underlying	Due to (or as a conseque	ence of):								
	and -trans	kami	Cause (Disease or injury that initiated events resulting in death) Last	c									
8760,	icate be executed physician and the burial-transit	dical Examine		Dao 10 (01 a3 a conseque	31100 017.								
687	ificate g phys as the												
.O. Box	res that the death certifi igned by the attending be detached for use as	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregnan 1 □ Live birth 2 □ Fetal o 4 □ Pregnant at time of dea 9 □ Unknown		23	23d. Date of delivery Month Day Year						
S, P	s that ined b e deta	y Pt	Part II. Other significant conditions cor	tributing to death but not result	ting in the un	iderlying cause giv	en in Part I.	23e. Did to	bacco use	contribute to t	he cause of death?		
ord	w require been sig should b							1 🗆 Y	es 2	No 3□ Prot	pably 4 □Unknown		
Vital Record	The ta ate has page 2	Completed						24a. Was autop perfor 1 \sum Yes	sy	24b. Were auto prior to co death? 1 🗆 Yes	ppsy findings available impletion of cause of 2 No		
Ĭ Ĭ	Physician: rthis certific ral director,	Be	25. Was case referred to medical examiner?	ospital:		Oth	or	eath Check only o					
ō	<b>□</b> = a	n; To	27. Manner of Death	28a. Date of Injury	R/Outpatient 28b. Time of	28c. Injur	4 🗆 Nursing	Home 5 Resid			(y)		
ion	ath. or: Afte	atio	1 ★Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury		k? Yes 2 □ No						
Division of	tai or Atters after de al Directo	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hom building, etc. (Specify)	ne, farm, stre	eet, factory, office		28f. Location (S City or Tow	treet and in, State)	Number or Rura	al Route Number,		
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: Attercompletely filled in by the fune.	edical	(Check only 2 Medical Examilione)	sician: To the best of my know ner: On the basis of examination and manner stated.	ledge, death on and/or inv	estigation, in my o	pinion, death occ	ce, and due to the courred at the time, o	ause(s) ar late and p	nd manner as s lace, and due to	tated. o the cause(s)		
_	To T To 1	Σ	29b. Signature and title of certifier	C 10 1		29c. Licens	e number		29d. Date	signed (Month,	Day, Year)		
	1		1 Hall le	an Lust		000	2882	18	101	25106	711		
5	1		30. Name and address of person who co	. \	23a) (Type, F	Cal S	Lool	225	.Cee	u St	Balt		
	Sta Registr		31. Date filed (Month, Day, Year) NOV 0 3 2	32. Registrar's Signatu	ire	CONE							

amend #20b Per FH 2861 11/06/06 JH

Amend Items 12861 14/06/06 For State Registrar 35000 Item 31 per DVR Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day October 24 **Physician** Neidigh 4:10 A M Hazel Marie 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Frederick Memorial Hospital Frederick 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex **Funeral** 8. Date of Birth (Month, Day, Year) Months Days Min 1 ☐ M 2 🕱 F Hours 304-18-1322 86 Director 02/05/1920 IN Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f ehow the Medical Examiner must be notified at MD Frederick Frederick 1 Yes 2 No Director 10g. Citizen of What Country? USA 10e. Street and Number 10f. Zip Code with 6102 Pine Crest Lane 21701 Pages 1 and 2 should be filed within 72 hours after deathnent of Health and Mental Hygiene. Funerai 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ∐Yes 2 XNo If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specity: Specify: White þ 3X Widowed 4 ☐ Divorced Year or Dates Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 7 is marked other than traumatic event, the Me Elementary/Secondary (0-12) Cotlege (1-4or 5+) Executive Secretary Military 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Eva Geraldine Vest Robert Winford Chipman ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carmel, IN 46033 Denny Heidigh / Son 345 4th. East item 2 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Department of Himportant: If its eny injury or ot once. 1 ☐ Burial 2 ☐ Cremation 3 🙀 Removal from State Grandview Cemetery 10-28-06 Bloomfield, IN 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Euneral Service Licensee Charles L. Stevens Funeral Home, Inc. 1501 East Fort Avenue, Baltimore, MD 21230 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death tmmediate Cause (Final disease or condition resulting in death) -ordia Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): The law requires that the death certificate be executed anding physician and use as the burial-transit Exam that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medicai IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 2 Fetal death 3 Ectopic pregnancy Year Month Day 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☑ No 9 ☐ Unknown the a 9☐ Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. ģ 1 Yes 2 No 3 Probably 4 Unknown been si Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has b firector, page 2 s autopsy performe 2 No 1 ☐ Yes 2 ☐ No Vital 1 ☐ Yes or Attending Physician: Be 25. Was case referred to medicat examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification; To 20-10 1 ☐ Yes 2 ER/Outpatient 3 □ DOA 1 🗌 Inpatient this Division of : After thi 28b. Time of Injury 27 Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 2 M investigation 1 ☐ Yes 2 ☐ 10 death i Director: / 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Ptace of tnjury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number City or Town, State) determined 4 - Homicide within 24 hours after To the Funeral Dire To the Hospitei 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 24th 2006 of person who completed cause of death (ttem 23a) (Type, Print) 31. Date filed (Month, Day, King) 0 3 2 Registrate Signature State Registrar